

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED			2b. HOUR	
MARY			KATHERINE			ALLEN			Apr. 10 1968 1 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR
Female	White	June 26, 1966	1 YRS 9 15					Apr. 10 1968		M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Berkeley Co.		U.S.A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			437 No. Mulberry Street			---			----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Washington		Hagerstown		YES		437 No. Mulberry Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Robert Lee Allen				Frances Elizabeth Hopkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No			No		Frances E. Allen-Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to asphyxiating gas</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Constrictive + Strangulation by tracheal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Compensation</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Estimate 1-5 Min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>9240</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4-10-68 10 P.M.</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Strangled in Crib by Belt</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>437 N. Mulberry St. Hagerstown, Md. Wash</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Edward W. Ditto</u>			EXAMINER'S NAME (Type) Edward W. Ditto 111			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>4-10-68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Apr. 12, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Martinsburg Berkeley, W. Va.</u>		
24. FUNERAL DIRECTOR <u>Howard K. Brown</u>			ADDRESS <u>Brown Funeral Home-Martinsburg, W. Va.</u>			25a. REC'D BY REGISTRAR <u>APR 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MIDDLE										DATE OF DEATH		HOUR	
1. DECEASED-NAME (Type or print) Lillian Minerva Anderson										2a. DATE OF DEATH April ^{Month} 9 ^{Day} 1968		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 17 1910				6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 22		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington				Md.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If no give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Keedysville Md RFD #1			
14. FATHER'S NAME First Harry Middle L. Last Heffner				15. MOTHER'S MAIDEN NAME First Anna Middle M Last Duey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 219-20-4642		17. INFORMANT Address Mr. Lloyd L. Anderson Keedysville Md RFD #1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Colon 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) Thrombus celiac artery (c) Arteriosclerosis CV disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 hrs 1 week			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral heart failure, Cerebral thrombosis													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 1962 to April 9, 1968 , that (I) (we) last saw the deceased alive on April 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE L. L. Packer Jr				DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 10, 1968					
22d. PHYSICIAN'S NAME (Type) L. L. Packer Jr				22e. ADDRESS Hagerstown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 11-68		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City or Town) (County) Williamsport, Maryland						
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Maryland				ADDRESS		25a. REC'D BY REGISTRAR APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06226

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06232

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			7:11 P.M.				
Linda			Sue			Ayres			April 18, 1968			P.M.				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			Month Day Year			7:11 P.M.		
Female	White	Jan. 26, 1954	14 YRS.					April 18,			1968			P.M.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.				
Nebraska			U.S.A.						Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington County Hospital			Student										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
W.Va.			Berkeley			Martinsburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			820 Maryland Avenue				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
George E. Ayres			Rita J. Hosch													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			No			Mrs. Rita J. Ambrose-Martinsburg, W.Va.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebellar Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237X																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED										
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			April 19, 1968										
Dr. E. W. Ditto, Jr.			215 W. Washington St., Hagerstown, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial			Apr. 21, 1968			Rosedale Cemetery			Martinsburg-Berkeley W.Va.							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Brown Funeral Home-Martinsburg, W.Va.			Howard R. Brown			APR 22 1968			Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Goldie Marie Baechtel						4 Month 16 Day 68 Year			5:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years (last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
female		white		Oct 11, 1900			67			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.
Md.		USA				Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			917 Mulberry Ave.			agent			insurance	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			wash.		Hagerstown				917 Mulberry Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George P. Houser			Ella Mae Spessard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					Address
no			219-46-1101		Carroll L. Baechtel, Newark, Dela.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Stomach</u> <u>1519</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>151X</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Malnutrition, Generalized Metastasis - Anemia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7 Sept</u> , 19 <u>63</u> , to <u>date</u> , 19 <u>63</u> , that (I) (we) last saw the deceased alive on <u>15 April</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard T. Binford</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.								22e. ADDRESS 1135 Potomac Avenue Hagerstown, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		4/19/68		Rest Haven Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home Hagerstown, Md.						DATE APR 19 1968		<u>Charles Judge</u>		

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UNITED STATES DEPARTMENT OF JUSTICE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06234

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR							
CURTIS			LEE			BAER			4- 2 68			12:00							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		White		July 30, 1920		47 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year		24 PM					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH		Md.					
Maryland		USA										Washington							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Weverton				B. & O. Railroad Tracks				Brakeman				Railroad							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER			
Maryland				Washington				Sandy Hook				YES X NO				Main Street			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
First Middle Last						First Middle Last													
Ollie Osborn Baer						Emma May Barnhart													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT							
No						None						Mrs. Luella Baer							
						214-14-6347						RFD# 2, Knoxville, Md. 21758							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) 802.0 Crushing injury of abdomen and chest												Sudden							
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
800X																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES NO X							
21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
CAUSE OF DEATH						12:00 P.M. 4/2/ 68						Derailment of railroad cars crushing the victim.							
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town State							
WHILE AT WORK X NOT WHILE AT WORK						B&O R.R. Tracks						Weverton, Maryland, Washington Co							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry, and in my opinion death resulted from: Natural causes, Accident X, Suicide, Homicide, Undetermined manner																			
22b. DATE SIGNED																			
4/4/68																			
ACTUAL SIGNATURE						M.D.													
EXAMINER'S NAME (Type)						Howard N. Weeks, M. D.													
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY							
Burial						4/5/68						Brownsville Heights							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE							
Donald Eickley						Harpers Ferry, W. Va.						APR 8 - 1968 Charles Judge							

10-25-33

Male White 101 30, 1020 47

Washington

Everson E. & C. Railroad Tracks

Washington Army Hook X Main Street

Willie George Gant
Mrs. Annie East
214-14-0247 Knox 2, Knoxville, Md. 21728

Office

Brownsville, Wash., Md.
Brownsville Heights
Harpers Ferry, W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CHARLES MONDEL BAKER			2a. DATE OF DEATH Month 4 Day 5 Year 68			2b. HOUR M					
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MAY 2 1900		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY LABOR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABOR			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HANCOCK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 132 E. MAIN ST.		
14. FATHER'S NAME First Middle Last CHARLES H BAKER			15. MOTHER'S MAIDEN NAME First Middle Last NETTIE MYERS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address MD. MONDEL J BAKER 132 E. MAIN ST. HANCOCK						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5900 broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3 mos (b) emphysema DUE TO, OR AS A CONSEQUENCE OF (c) chronic pyelonephritis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 6000											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John J. Donoghue M.D.			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) John J. Donoghue, M.D.			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4.9.68		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW			23d. LOCATION (City or Town) (County) (State) RURAL CUMBERLAND ALLEGANY				
24. FUNERAL DIRECTOR ADDRESS Howard J. Hume Hancock Md						25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ROY EDWARD BAKER			2a. DATE OF DEATH APRIL Month 7 Day 1968			2b. HOUR 5 A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2/17/1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
1d. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during 1 year ending 1-1-68) RETIRED CLERK		12b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1024 PENNSYLVANIA AVE.	
14. FATHER'S NAME First Middle Last RUSH F. BAKER			15. MOTHER'S MAIDEN NAME First Middle Last ELLA REISHER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES W.W.#1		16b. SOCIAL SECURITY NO. 705-10-6220		17. INFORMANT HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver (proliferative) 197.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemochromatosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 6 mo - 6 yrs ?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1561 Pulmonary emphysema									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-22, 1940 to 4-7, 1968 , that (I) (we) last saw the deceased alive on 4-6-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Hornbaker M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-8-68			
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22e. ADDRESS 154 West Washington St., Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 4/9/68		23c. NAME OF CEMETERY OR CREMATORY CEDAR GROVE CEM.		23d. LOCATION (City or Town) (County) (State) CHAMBERSBURG FRANKLIN PA.			
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First Middle Last Nelle Belle Beard			2a. DATE OF DEATH Month Day Year April 7, 1968		2b. HOUR 6:00P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 30, 1891		6. AGE (In years lost birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS 7 7
7a. BIRTHPLACE (State or foreign country) Hockingham Co.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9 N. Main St.	
14. FATHER'S NAME First Middle Last Frank Dorman	15. MOTHER'S MAIDEN NAME First Middle Last Ella Miltenberger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.		
16b. SOCIAL SECURITY NO. 220-30-7622		17. INFORMANT Address Md. Mr. A. Blair Beauchamp, 9 N. Main St. Boonsboro			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 430.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Day					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 330X Adeno-carcinoma of left Breast					
19a. DATE OF OPERATION 4-2-68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adeno carcinoma	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-2- , 19 68 , to 4-7- , 19 68 , that (I) (we) lost the deceased alive on 4-7- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph Secordari		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-8-1968		
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI		22e. ADDRESS Boonsboro Md 21713			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-10-68	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr.		ADDRESS 112 N. Main St. Boonsboro, Md.	25a. REC'D BY REGISTRAR DATE APR 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 400 5-15 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Ivern Deneen Beckett			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4 13 1968			2b. HOUR 6:00 PM									
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH Feb 26 1968	6. AGE (In years last birthday) YRS. 1 19	IF UNDER 1 YEAR MONTHS 1 DAYS 19	IF UNDER 24 HRS. HOURS 1 MIN. 19	2c. DATE PRONOUNCED DEAD Month 4 Day 13 Year 19 68			2d. HOUR 7:15 PM						
7a. BIRTHPLACE (State or foreign country) Hagerstown Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington									
10. CITY OR TOWN OF DEATH Hagerstown Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Washington			13b. CITY OR TOWN Hagerstown		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 117 W. Church Street									
14. FATHER'S NAME Charles Church			15. MOTHER'S MAIDEN NAME Leslie Beckett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.	17. INFORMANT Leslie Beckett		ADDRESS 117 W. Church Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7581 SD II DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Aspiration (b) PIVULUS!! DUE TO, OR AS A CONSEQUENCE OF vomitus & pulmonary edema (contributory- hypoplasia adrenals) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7593										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town		County		State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-13-68			
ACTUAL SIGNATURE Edward W. Ditto III		EXAMINER'S NAME (Type) DR. EDWARD W. DITTO III		M.D. 217 W. WASHINGTON ST. HAG. MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-16-1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown Md		(County)		(State)					
24. FUNERAL DIRECTOR John R. Watson of Hagerstown Md				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

DR. EDWARD W. DITTO III
217 W. WASHINGTON ST. HAG. MO.

Thruout this illness the patient was attended by Dr.. Adson Moody

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06239

1. DECEASED-NAME (Type or print) WARREN THEADORE BERGUM			2a. DATE OF DEATH Month April Day 15 Year 1968			2b. HOUR 4.30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH sept 30 1914		6. AGE (In years last birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrical		12b. KIND OF BUSINESS OR INDUSTRY Fairchild	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Washington Hagerstown		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 124 Randolph Ave	
14. FATHER'S NAME First Middle Lost Dr O.T. Bergum			15. MOTHER'S MAIDEN NAME First Middle Lost Elizabeth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No		16b. SOCIAL SECURITY NO. 708-07-3896		17. INFORMANT Address Mrs Bertha N. Bergum 124 Randolph Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 4109 DUE TO, OR AS A CONSEQUENCE OF Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } Arteriosclerotic heart disease lost. 4-20-68 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Indefinite	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obesity, exogenous, severe							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 4-12-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-1-1968 , 19____, to 4-3-68 19____, that (I) (we) last saw the deceased alive on 4-12-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert F. Keadle		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-1968	
22d. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		22e. ADDRESS Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR APR 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and deposit them in the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Transmit this letter and enclose the same to the person named in the address below and return the receipt to the sender.

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Mr. J. H. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
30M REV. 1/68

08234

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06240

1. DECEASED-NAME (Type or print) Stephanie Catherine Boden		2a. DATE OF DEATH April Month 5 Day 68 Year		2b. HOUR 10:45 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH April 5, 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 308 Englewood Road		12b. KIND OF BUSINESS OR INDUSTRY none	
14. FATHER'S NAME First Middle Last Robert Boden		15. MOTHER'S MAIDEN NAME First Middle Last Claire Sallade		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Robert Boden Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane 7761 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Little - Blood incompatibility - Combs + DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 24 hrs < 24 hrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 7730					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/5 , 19 68 , to 4/5 , 19 68 , that (we) last saw the deceased alive on 4/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard A. Young		22c. DATE SIGNED 4/6/68		22d. PHYSICIAN'S NAME (Type) Richard A. Young M.D.	
22e. ADDRESS 101 King St Hag., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/6/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City or Town) Hagerstown, Md.		23e. REC'D BY REGISTRAR Charles Judge			
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		24b. ADDRESS		24c. REGISTRAR'S SIGNATURE Charles Judge	
24d. DATE APR 9 - 1968					

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RECEIVED 04-1-58

UNITED STATES DEPARTMENT OF JUSTICE

44-10

Department of Justice

April 1, 1958

White

April 1, 1958

Total

USA

Washington

Washington

Washington Co. Office

10

10

10

None

None

None

10

None

None

None

Washington Co. Office

Washington Co. Office

Washington Co. Office

Washington Co. Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Sara	Middle Lynn	Last BRAGDON	20. DATE OF DEATH Month Day Year April 20, 1968		2b. HOUR P 5:15 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 13, 1963		6. AGE (In years lost birthday) 5 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to institution) West Virginia		13b. COUNTY Jefferson		13c. CITY OR TOWN Bakerton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Burnett Ellis Bragdon		15. MOTHER'S MAIDEN NAME First Middle Last Mary Jane Vinyard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Burnett E. Bragdon Box 51, Bakerton, West Va. 25410							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>1929</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain tumor in posterior fossa (medulloblastoma) Sev. mos.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1930</u>											
19a. DATE OF OPERATION <u>4-16-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-14-68</u> , 19 <u> </u> , to <u>4-20-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4-20-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. F. Abdullah</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED April 24, 1968					
22d. PHYSICIAN'S NAME (Type) A. F. ABDULLAH, M. D.		22e. ADDRESS 318 N. Potomac St., Hagerstown, Md. 21740									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/68		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Wash., Md.					
24. FUNERAL DIRECTOR <u>Donald Backs</u> ADDRESS Harpers Ferry, W. Va. 25425		25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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April 30, 1900

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Letter and Reception

Journal of Management Education 30(6)

May 1964

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CHAS. J. JOHNSON, JR., 1000 N. 10th St., Phoenix, Ariz.

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 18, 22a film 399

4-25-68 mt

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06242

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M								
Grace			Elizabeth			Brandenburg			April 3, 1968								
3. SEX Female			4. RACE White			5. DATE OF BIRTH Sept. 30, 1888			6. AGE (In years last birthday) 79 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 832 Potomac Ave.					
14. FATHER'S NAME Charles T. Leatherman			15. MOTHER'S MAIDEN NAME Mary C. Routzahn														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no no			16b. SOCIAL SECURITY NO. none			17. INFORMANT Mrs. Hazel B. Moss 832 Potomac Ave. Hagerstown, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalitis, meningitis</u> <u>3200</u> DUE TO, OR AS A CONSEQUENCE OF <u>hemophilus influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3400</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiac Dis</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>21 Mar</u> , 19 <u>64</u> , to <u>3 Apr</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>2 April</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>natural causes</u>																	
22b. SIGNATURE <u>Richard T. Binford</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4 April 68											
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.			22e. ADDRESS 1135 Potomac Avenue Hagerstown, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 5, 1968			23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown Maryland.								
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE APR 8 - 1968			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

10-10

STATEMENTS OF DEATH

36930



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First DAISY	Middle GERTRUDE	Last BROOKS	2a. DATE OF DEATH Month 4 Day 8 Year 68		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 9.27.05		6. AGE (In years 62 birthday)		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RURAL 1
14. FATHER'S NAME		First MILLARD F	Middle BISHOP	15. MOTHER'S MAIDEN NAME		First ANNIE B	Middle MUNSON	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address LEONARD B BISHOP RURAL 1 HANCOCK MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 5900 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pyelonephritis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 6000								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John J. Donoghue M.D.</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) John J. Donoghue, M.D.				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4.11.68		23c. NAME OF CEMETERY OR CREMATORY MT OLIVET		23d. LOCATION (City or Town) (County) (State) MD. RURAL 1 HANCOCK WASHINGTON		
24. FUNERAL DIRECTOR <u>Howard F. House Hancock Md</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year	2b. HOUR
JAMES WILLIAM CHAPMAN					APRIL 10 1968	9:15 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year
MALE	WHITE	JAN. 24, 1912	56 YRS.			APRIL 10 1968
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
WEST VIRGINIA		U.S.A.				WASHINGTON Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN		WASHINGTON CO. HOSPITAL		FARM LABORER		FARMING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND		WASHINGTON		HAGERSTOWN		712 SECURITY ROAD
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	
WILLIAM R. CHAPMAN					NELLIE CARROLL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO		213-12-7229		MRS. CATHERINE L. CHAPMAN, HAGERSTOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pontine Hemorrhage - extension</u> DUE TO, OR AS A CONSEQUENCE OF <u>into old brain + ventricular system</u> (b) <u>Hypertensive vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>10 yrs</u> 4310 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary emphysema + nephrosclerosis, benign of hyaline arteriosclerosis</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED		
EDWARD W. DITTO, III, M.D.		M.D.		4/11/68		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		217 W. WASHINGTON		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		HAGERSTOWN, MARYLAND		
ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		4/13/68	SHANKTOWN CEMETERY		SHANKTOWN, WASH. CO. MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Nelson L. Eschelberger		ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND.		DATE		APR 16 1968

3836

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <u>Florine Sarah Christ</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>68</u>			2b. HOUR <u>5:50 P</u>					
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>9-5-1922</u>		6. AGE (In years last birthday) <u>46</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u> Md.					
10. CITY OR TOWN OF DEATH <u>Williamsport</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Homewood Church Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u></u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Balto</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>3305 Woodstock Ave</u>		
14. FATHER'S NAME First <u>John</u> Middle <u>William</u> Last <u>Dietz</u>			15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle <u>Sarah</u> Last <u>Aichele</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>213-05-73384</u>		17. INFORMANT Address <u>2750 Va Ave Md.</u> <u>Mark & Wagner Williamsport 21795</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive C.V. Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u> <u>Arthritis of Cervical Spine</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-22-1968</u> , to <u>4-25-1968</u> , that (I) (we) last saw the deceased alive on <u>4-25-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert P. Conrad, MD</u> DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>4-25-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22e. ADDRESS <u>137 W. Washington Stagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/29/68.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Finney</u>					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the Health Department's copy. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Raymond Milford Churchey			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month April Day 3 Year 1968			2b. HOUR 3 P M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Sept. 30, 1911	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS 8 DAYS 3	IF UNDER 24 HRS HOURS 3 MIN 0	2c. DATE PRONOUNCED DEAD Month April Day 3 Year 1968		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Near Sharpsburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mondel Road			12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Mailchild
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Nr. Sharpsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Mondel Road	
14. FATHER'S NAME First George Middle Washington Last Churchey			15. MOTHER'S MAIDEN NAME First Fannie Middle Frances Last Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 213-18-9345		17. INFORMANT ADDRESS Mrs. Patsy Milburn Sharpsburg, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gunshot wound Through chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 976 X								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 3 P.M. Apr 3 '68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) self inflicted			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Mondel Rd City or Town Sharpsburg County Washington State MD				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) H.N. WEEKS			M.D.			22b. DATE SIGNED 4/4/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Washington, Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland					25a. REC'D BY REGISTRAR APR 8 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

00240

100-100000



CONFIDENTIAL

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <div>06241</div> <div> <div>MD</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div style="text-align: right;">06247</div> </div>											
1. DECEASED-NAME (Type or Print) First Middle Last SADIE M. CORWELL						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> APRIL 14 1968		2b. HOUR 11:05 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/3/1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 15, 1968	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH RURAL FAIRPLAY				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT#1 FAIRPLAY				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY WASHINGTON		13c. CITY OR TOWN FAIRPLAY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT#1 FAIRPLAY	
14. FATHER'S NAME First Middle Last HARRY K. PALMER				15. MOTHER'S MAIDEN NAME First Middle Last ALTA DUSING				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. NONE				17. INFORMANT ADDRESS MRS. ESTHER P. CRAMER HAGERSTOWN MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4290 Massive Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Hypertrophy DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4344											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 215 W. Washington St., Hagerstown, Md.				22b. DATE SIGNED April 16, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/17/68		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR ADDRESS W. J. Florman, Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE APR 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

NAME: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

POSTMORTEM FINDINGS: [illegible]

LABORATORY TESTS: [illegible]

TOXICOLOGY: [illegible]

FORENSIC MEDICINE: [illegible]

PATHOLOGY: [illegible]

ANTHROPOLOGY: [illegible]

ODONTOLOGY: [illegible]

ENTOMOLOGY: [illegible]

FORENSIC SCIENCE: [illegible]

LABORATORY: [illegible]

TOXICOLOGY: [illegible]

FORENSIC MEDICINE: [illegible]

PATHOLOGY: [illegible]

ANTHROPOLOGY: [illegible]

ODONTOLOGY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

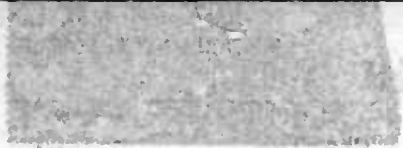
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First <i>Geraldine</i>	Middle <i>Palmer</i>	Lost <i>Cox</i>	2a. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>1968</i>		2b. HOUR <i>M</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 9, 1932</i>		6. AGE (In years lost birthday) <i>35</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Greencastle, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1589 Broadfording Road</i>			
14. FATHER'S NAME First <i>Harry</i>		Middle <i>Benton</i>		Lost <i>Zimmerman</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i>		Middle <i>Kathryn</i>		Lost <i>Kendall</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>168-26-4422</i>		17. INFORMANT Address <i>G.L. Cox 1589 Broadfording Rd. Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.3</i> <i>400.3</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Wemicia</i> <i>Wemicia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Malignant hyperthermia</i> <i>2 yrs</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>2 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>445X Total pneumonia, pericarditis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1966</i> to <i>April 1968</i> , that (I) (we) last saw the deceased alive on <i>April 7 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edson B. Moody</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-8-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dr. Edson B. Moody</i>		22e. ADDRESS <i>363 S. Cleveland Ave. Hagerstown, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/11/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>					
24. FUNERAL DIRECTOR <i>W. G. Hork</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. RECORD REGISTRAR DATE <i>APR 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE										2a. DATE OF DEATH		2b. HOUR	
1. DECEASED-NAME (Type or print) Charles Edward Crampton										Month April Day 12 Year 1968		M 	
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 28 1884		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 13		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (State or foreign country) Sharpsburg Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Washington Co.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor		12b. KIND OF BUSINESS OR INDUSTRY Roads							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First John Middle W Last Crampton		15. MOTHER'S MAIDEN NAME First Francis Middle E. Last Gray											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 		17. INFORMANT Address Mr. Charles E. Crampton Jr. Sharpsburg Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Embolism and Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Heart Disease & Fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1200 severity and poor nutrition													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from April 2, 1968 , to April 12, 1968 , that (I) (we) last saw the deceased alive on April 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.													
22b. SIGNATURE R. Amarillo		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/68									
22d. PHYSICIAN'S NAME (Type) R. Amarillo		22e. ADDRESS Sharpsburg, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15-68		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg Wash. Md.							
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Md.		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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06244

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06250

1. DECEASED-NAME (Type or print)		First Shana		Middle Lee		Last Crawford		2a. DATE OF DEATH Month April Day 18 , Year 1968			2b. HOUR 2:10 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 18, 1968			6. AGE (In years last birthday) 0 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 15	
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rfd. 2			
14. FATHER'S NAME First Larry Middle Crawford Last Lowry			15. MOTHER'S MAIDEN NAME First Deborah Middle Lowry Last Lowry									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No.		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Hagerstown Paul L. Lowry, 1818 Helsterboro, Rd. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7769 Atelectasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7625												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE F. D. Dove Jr. M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/19/68		
22d. PHYSICIAN'S NAME (Type) F. D. Dove, Jr., M. D.		22e. ADDRESS 363 S. Cleveland Avenue Hagerstown, Maryland 21740										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-19-68		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Tilghmanton Wash. Co., Md.						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				ADDRESS		25a. RECEIVED BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Millard Ellsworth Crilley			2a. DATE OF DEATH Month April Day 30 Year 1968			2b. HOUR 10:30 P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/15/91			6. AGE (In years lost birthday) 77 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Taxi driver		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 211 W. Main St.	
14. FATHER'S NAME First Middle Last SAMUEL A. CRILLEY			15. MOTHER'S MAIDEN NAME First Middle Last Catherine Holbert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-32-5036		17. INFORMANT Address HANCOCK MD. MATHIELD E CRILLEY 211 W. MAIN ST.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years 4 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from Jan. 30 , 19 68 , to Apr. 30 , 19 68 , that (I) (the hospital) last saw the deceased alive on April 30 , 19 68 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Domingo A. Garcia DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 5/1/68			
22d. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA, M.D.		22e. ADDRESS Western Md. State Hospital, Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5.3.68		23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CATHOLIC		23d. LOCATION (City or Town) (County) (State) HANCOCK MD WASHINGTON MD			
24. FUNERAL DIRECTOR Howard J. Moore ADDRESS Hancock Md				25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Catherine Elmira Cross						Month Day Year April 12 1968			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		February 9, 1924			44 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Hagerstown, Md.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hospital			Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown		YES		114 Buena Vista Ave.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Feilder Noah Selby			Fannie Elmira Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			219-12-0302		C.E. Cross, Sr. 114 Buena Vista Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>									1 day
3949 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>410 X</u>									
(b) <u>Myocardial Stenosis, marked</u>									1 yrs.
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Arteriosclerotic Cardiac Dis.</u>									ys. (?)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Nephrosclerosis advanced; Cardiac failure; Atelectasis, Opt. Ang.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Jan</u> , 19 <u>62</u> , to <u>12 Apr</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12 April</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard T. Binford</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 13 April 68		
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.					22e. ADDRESS 1125 Potomac Avenue Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/16/68		Rest Haven Cemetery		Hagerstown - Washington - Md.			
24. FUNERAL DIRECTOR <u>Wm. G. Hoss</u>					ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Danitel Webster Cunningham					2a. DATE OF DEATH April 25, 1968			2b. HOUR 1 A.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH Sept. 1, 1877		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Williamsport			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer		12b. KIND OF BUSINESS OR INDUSTRY farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RFD 6	
14. FATHER'S NAME First Middle Last George Cunningham				15. MOTHER'S MAIDEN NAME First Middle Last Anna Cosey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address William Cunningham, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Of The Face DUE TO, OR AS A CONSEQUENCE OF (c) Senility									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-1 , 19 67 , to 4-25-68 , 19 68 , that (I) (we) last saw the deceased alive on 4-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. W. Ditto, Jr. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED April 26, 1968					
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.					22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4-28-68		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash, Md.				
24. FUNERAL DIRECTOR Minich Funeral Home, Hagerstown, Md. ADDRESS					25a. REC'D BY REGISTRAR APR 29 1968 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mabel First Middle Bell Last Dixon		2a. DATE OF DEATH April Month 21 Day 1968 Year		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 20 1886	
7a. BIRTHPLACE (State or foreign country) Blackstone Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS 11 DAYS 1	
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 43 E. Church St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport	
14. FATHER'S NAME First Randolph Middle Bagley Last Unknown		15. MOTHER'S MAIDEN NAME First Polly Middle Unknown Last Unknown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) -----		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Arlene Strain Williamsport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4129 DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 20 yrs (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Smile
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4330 None					
19a. DATE OF OPERATION 1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from PAUL , 19 67 , to April , 19 68 , that (I) (we) last saw the deceased alive on Mar. 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M.E. Byrkit M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-22-68	
22d. PHYSICIAN'S NAME (Type) M.E. Byrkit M.D.				22e. ADDRESS 20 West Potomac St. Williamsport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 24-68		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Maryland		23d. LOCATION (City or Town) (County) (State) Williamsport Washington Md.		25a. REC'D BY REGISTRAR DATE Apr 24 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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Integral, Indefinite, Definite, and Double

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

06249				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06255							
1. DECEASED-NAME (Type or print)				First	Middle	Lost	20. DATE OF DEATH				2b. HOUR				
WALTER				LEWIS	DOWNS		APRIL Month 5 Day 1968 or				5:30 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
MALE		WHITE		1/2/1890			78 YRS.		MONTHS		DAYS				
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
MARYLAND		U.S.A.				WASHINGTON									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done)				12b. KIND OF BUSINESS					
RURAL BOONSBORO		RT.#1 BOONSBORO				RETIRED FIRST CONDUCTOR				ROAD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
MARYLAND		WASHINGTON		BOONSBORO		NO <input checked="" type="checkbox"/>		RT.#1 BOONSBORO							
14. FATHER'S NAME				First	Middle	Lost	15. MOTHER'S MAIDEN NAME				First	Middle	Lost		
FREELAND				DOWNS			MARY				KATE	S PRECHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT								Address	
NO				214-09-9759		MRS. LUCY YOUNG RT.#1 BOONSBORO MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY												SUDDEN			
411.9 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) SEVERE ARTERIO SCLEROSIS															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4201															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
		HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from 4/3, 1968, to 4/5, 1968, that (I) (we) lost the deceased alive on 4/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
R. Amarillo										4/6/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS											
R. Amarillo				Sharpsburg, Md.											
23a. BURIAL CREMATION REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
REMOVED		4/8/68		CEDAR LAWN MEM. GARDENS		HAGERSTOWN WASH. MD.									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. J. Norment				Hagerstown, Md.				DATE APR 9 - 1968		J. Charles Judge					

CASEC

0521-8758/96/0004-0000\$05.00/0

RESULTS

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06256

1. DECEASED-NAME (Type or Print) Audrey V. Fleagle			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 4 30 1968				2b. HOUR 2:40 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 7, 1938	6. AGE (In years last birthday) 30 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 4 Day 30 Year 1968				2d. HOUR 2:40 PM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington Co.						Id.
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Co. Landis Tool			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.			13b. COUNTY Franklin		13c. CITY OR TOWN Quincy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 32			
14. FATHER'S NAME Vernon C. Fleagle			First Middle Last			15. MOTHER'S MAIDEN NAME Dorothy Mae Kline			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 192-30-1703			17. INFORMANT ADDRESS Mr. Vernon C. Fleagle Rouzerville, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8190 (b) Cerebral Contusion DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-20 Hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1254												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 4 30 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of Auto, crashed while hit med due						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt #64 Road			21f. LOCATION Street or R.F.D. No. Rt #64 2 Mi. N. Smithsburg Wash Md						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Edward W. Ditto III			EXAMINER'S NAME (Type) Dr. Edward W. Ditto, III.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4-30-68			
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
						ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE OF CEMETERY OR CREMATORY 5/2/1968			23d. LOCATION (City or Town) Washington Twp., Franklin, Pa.			(County) (State)			
24. FUNERAL DIRECTOR Walter Z. Groce			ADDRESS Waynesboro, Pa.			25a. REC'D BY REGISTRAR MAY 01 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			

[The page contains extremely faint, illegible markings and bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Milton Haley Gillan			2a. DATE OF DEATH Month April Day 12 Year 1968			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH February 11, 1892		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Kohresville, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 920 Hamilton Blvd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Ice Cream		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 920 Hamilton Blvd.	
14. FATHER'S NAME First John Middle Gillan Last Indiana			15. MOTHER'S MAIDEN NAME First Indiana Middle Miller Last Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-09-0696		17. INFORMANT Address Mrs. M. H. Gillan 920 Hamilton Blvd. Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease, arteriosclerotic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant 14 yr.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 23, 1952 to April 12, 1968 , that (I) (we) last saw the deceased alive on May 23, 1966 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE B. B. Kneisley, M.D.					22c. DATE SIGNED April 15, 1968					
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.					22e. ADDRESS 148 West Washington Street Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md				
24. FUNERAL DIRECTOR W. C. Hunt ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE

200

January 11, 1961

Dear Sir:

Enclosed

is a copy of

the report of

the committee

on the subject of

the activities of

the committee

on the subject of

the activities of

the committee

on the subject of

the activities of

the committee on the subject of the activities of

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FOR STATE HEALTH DEPT.

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>06252</div> <div>06258</div>									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH		2b. HOUR	
IRVIN			J. GROVE			Month Day Year		4 25 1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	10/4/1907	60 YRS.			Month Day Year		4 25 1968	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				Washington Co., Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			418 W. Antietam			Farmer & Miller		Planes	
130. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Penna.			Franklin			State Line		State Line - Box 155	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JACOB A. GROVE			FLORENCE E. STRIFE						
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			219-12-2397			Mrs. Ethel Grove - State Line, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION									1 week
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) ATHEROSCLEROSIS									1 yr
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201 Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
H.N. WEEKS			650 Northern Ave			4/25/68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
H.N. WEEKS			Washington Co.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)			
Burial		4/28/68		Cedar Lawn Mem. Gardens		Hagerstown, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A.E. Munnich - Greencastle, Pa.						DATE		APR 29 1968	
								Charles Judge	

1952

1952

Handwritten notes and signatures, including a large signature in the center and a circular stamp at the bottom.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last PAUL SENFT HAMM		2a. DATE OF DEATH Month 17 Day 1968 or		2b. HOUR 3:50 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10/21/1906	
6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH WASHINGTON Md.		10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY FRUIT MKT.		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	
13b. CITY OR TOWN WASHINGTON		13c. COUNTY HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1300 DUAL HWY.		14. FATHER'S NAME First Middle Last HOWARD C. HAMM		15. MOTHER'S MAIDEN NAME First Middle Last ELIA SENFT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 213-18-8855		17. INFORMANT Address MR. CHARLES DOLL HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-jejunal-citaneous fistula 532.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding duodenal ulcer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos 1 wk					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5410 Obstructive jaundice					
19a. DATE OF OPERATION 4/7/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding duodenal ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/4/68 , 19 68 , to 4/17/68 , 19 68 , that (I) (we) lost saw the deceased alive on 4/17/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John A. Moran M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/18/68	
22d. PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.				22e. ADDRESS 215 W WASHINGTON ST. HAGERSTOWN, MD	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE 4/19/68		23c. NAME OF CEMETERY OR CREMATORY LECHEY'S UNION CH. CEM. SPRING GROVE PENNA.	
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN MARYLAND		24. FUNERAL DIRECTOR W. J. Norment Hagerstown, Md		25a. REC'D BY REGISTRAR APR 22 1968	
25b. REGISTRAR'S SIGNATURE [Signature]					

UNITED STATES OF AMERICA

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OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Harvey Edward Harding			2a. DATE OF DEATH Month April Day 14 Year 1968			2b. HOUR 1:00AM							
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 7, 1890		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS 11 DAYS 7		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (State or foreign country) London Co., Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Brownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) +++++++			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Brownsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER +++++++	
14. FATHER'S NAME First Middle Last John Harding			15. MOTHER'S MAIDEN NAME First Middle Last Mary Cockrell										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No.			16b. SOCIAL SECURITY NO. 705-09-3333			17. INFORMANT Address Mr. Kenneth E. Harding, Brownsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days - years -			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 chronic cholecystitis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-4-1960 , to 4-14-1968 , that (I) (we) last saw the deceased alive on 4-14-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joseph Secondary						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-15-1968				
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY						22e. ADDRESS BOONSBORO Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-16-68			23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery			23d. LOCATION (City or Town) (County) (State) Brownsville Wash. Co., Md.				
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR APR 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				

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U. S. A.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Richard Austin Harrell			2a. DATE OF DEATH Month Day Year April 16 1968		2b. HOUR A M 1:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3/4/14		6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) machinist-Linotype Newspaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5700 Queens Chapel Rd.			
14. FATHER'S NAME First Middle Last Hardee Harrell		15. MOTHER'S MAIDEN NAME First Middle Last Lena Fallin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-07-3306		17. INFORMANT Catherine J. Harrell Address 10412 Georgia Ave. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of pharynx					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days unknown 20 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 148 X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from Feb. 19 , 19 68 , to Apr. 16 , 19 68 , that (I) (we) last saw the deceased alive on April 16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Victor L. Ramos, M.D. DEGREE Victor Ramos, M. D.				22c. DATE SIGNED 4/16/68	
22d. PHYSICIAN'S NAME (Type) Victor Ramos, M. D.				22e. ADDRESS 1500 Pennsylvania Ave., Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		23e. LOCATION (City or Town) (County) (State) Silver Spring, Md.			
24. FUNERAL DIRECTOR Glen Carter Address 8434 Ga. Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR APR 19 1968 25b. REGISTRAR'S SIGNATURE J. J. Judge			

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MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06262

1. DECEASED-NAME (Type or print) CHARLES		First	Middle	Last	2a. DATE OF DEATH Month April Day 26 Year 1968		2b. HOUR 3:40 PM
3. SEX male		4. RACE white		5. DATE OF BIRTH August 5, 1881		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Ge. Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Frederick		13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Ezra		Middle Harshman		Last Harshman		15. MOTHER'S MAIDEN NAME First Catherine Middle Leatherman Last Harshman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-36-7126		17. INFORMANT Harry G. Harshman, Myersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydronephrosis DUE TO, OR AS A CONSEQUENCE OF (c) Benign Prostatic hypertrophy							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 610x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-28 , 19 66 , to 4-26 , 19 68 , that (I) (we) last saw the deceased alive on 4-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles F. Hess				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-29-68	
22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.				22e. ADDRESS Smithsburg, Maryland 21783			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-29-1968		23c. NAME OF CEMETERY OR CREMATORY Grossnickle's		23d. LOCATION (City or Town) (County) (State) Nr. Myersville, Fred, Md.	
24. FUNERAL DIRECTOR Paul F. Bittle		ADDRESS Myersville, Md.		25a. REC'D BY REGISTRAR APR 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00325

EXHIBIT OF DEATH

00326

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Name of informant: [illegible]

5. Address of informant: [illegible]

6. Name of physician: [illegible]

7. Name of funeral home: [illegible]

8. Name of cemetery: [illegible]

9. Name of burial place: [illegible]

10. Name of burial place: [illegible]

11. Name of burial place: [illegible]

12. Name of burial place: [illegible]

13. Name of burial place: [illegible]

14. Name of burial place: [illegible]

15. Name of burial place: [illegible]

16. Name of burial place: [illegible]

17. Name of burial place: [illegible]

18. Name of burial place: [illegible]

19. Name of burial place: [illegible]

20. Name of burial place: [illegible]

21. Name of burial place: [illegible]

22. Name of burial place: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-11-68
30M REV. 10-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lena Carolyn Harshman						April 24, 1968		5:10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		April 18, 1913		55 YRS.		MONTHS 0 DAYS 6 HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Boonsboro, Md.		U. S. A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington Co., Hospital			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington		Boonsboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		108 Della Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Daniel W. Emmert			Nettie B. Foltz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No.					Boonsboro, Md. Mr. Glenn S. Harshman, 108 Della Lane,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 2051 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myelogenous leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 4 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2041										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from June 1966, to April 24, 1968, that (I) (we) last saw the deceased alive on April 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edson B. Moody					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-29-68			
22d. PHYSICIAN'S NAME (Type) Edson B. Moody, M.D.					22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4-27-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.					MAY 6 1968		James Judge			

U.S. GOVERNMENT PRINTING OFFICE: 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
William Clay Hart						April 1 1968			4:00		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		June 4, 1907			60 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash. Co. Md.		U.S.A.				Washington Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown, Md.			Route 2			Patrolman			W. Md. R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown		#		Route 2		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Arthur G. Hart			Mary # Beard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			None		220-10-3464 Mrs Charlotte Hart, Route 2, Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>general arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Turned</u> <u>5-10 yr</u> <u>10 yr</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 13</u> , 19 <u>67</u> , to <u>Apr 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Mar 20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward W. Ditto III M.D.</u>						22c. DATE SIGNED <u>4-2-68</u>					
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.						22e. ADDRESS 217 W. Washington Street Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4/3/68		St. Pauls Cem.			Clear Spring Wash.		Md.	
24. FUNERAL DIRECTOR <u>Margaret Rowland, Clear Spring, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>APR 8 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

002587

DEPARTMENT OF HEALTH

002587

Male White June 4, 1907
Wash. D.C. U.S.A.
Residence, D.C.
Occupation, Washington
Army
Rank, U.S. Army
Service No. 100-100000
Date, June 4, 1907

History of illness
On June 4, 1907, the patient
was taken to the Washington
Hospital, where he was
admitted to the ward.
He was found to be
suffering from a severe
case of malaria, with
fever, chills, and
sweats. The patient
was treated with
quinine and other
medicines, and his
condition improved.
He was discharged
on June 10, 1907.

Signature of Physician
Date of Discharge
Place of Discharge

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21

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
ANNIE MARIA HARTLE							April 9 1968				5 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		white		Feby 14 1876			92 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland		USA					Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Williamsport			Williamsport Sanatorium			Housewife			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Washington		Hagerstown		YES		1122 Potomac Ave		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
John I. Summer						Annie M. Bahtel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO				none		Mrs Marie A. Hartsock			moller Apt			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis										Indefinite		
437.9 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis										Indefinite		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 334X (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
Chronic nephritis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19, 19 63, to April 9, 19 68, that (I) (we) last saw the deceased alive on March 8, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. B. Kneisley M.D.								DEGREE		22c. DATE SIGNED		
										April 10, 1968		
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS				
B. B. Kneisley, M.D.								148 West Washington Street				
								Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		4/13/68		Rose Hill Cemetery		Hagerstown Wash Co Md						
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Andrew K. Coffman Funeral Home Inc								DATE APR 18 1968		Charles Judge		

43330

43330



UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

TO: [Illegible]
FROM: [Illegible]
SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report with multiple lines of text, some of which are underlined or bolded.]

[Illegible text continues, including what appears to be a signature block and possibly a date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06266

1. DECEASED-NAME (Type or print) George Clark Hayes			2a. DATE OF DEATH Month April Day 20 Year 1968			2b. HOUR 9:40 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 22, 1878		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 28		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor Conv. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction			12b. KIND OF BUSINESS OR INDUSTRY Baldwin Locomotive Works		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Washington			13b. CITY OR TOWN Hagerstown		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #2				
14. FATHER'S NAME First Thomas Middle Last Hayes			15. MOTHER'S MAIDEN NAME First Lace Middle Last Milliken								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 165-03-6734A		17. INFORMANT Hagerstown, Maryland Mrs. Charles M. Snapp RFD #2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5021 (b) Chronic Bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with chronic brain syndrome											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 65 , to Apr , 19 68 , that (I) (we) lost saw the deceased alive on March 29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Spencer						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Apr 21, 1968			
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer						22e. ADDRESS 1455 Prospect St., Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (or city)		23b. DATE April 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City or Town) (County) (State) Philadelphia, Phila., Penna.					
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland.						25a. RECORDED BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

03230

EXHIBIT B-2011

03230

NO. 1000-1000

April

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Clark

The

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October 20, 1961

Mr.

Mr.

Washington

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (9)
30M REV. 11/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First MYRTLE			Middle BELLE			Last HELLER			2a. DATE OF DEATH 4 Month 25 Day 68 ^{year}			2b. HOUR 9 P M	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 4.29.1892			6. AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) CUMBERLAND MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.							
10. CITY OR TOWN OF DEATH HANCOCK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SEAMSTRESS			12b. KIND OF BUSINESS OR INDUSTRY GARMENTS							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HANCOCK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 128 W. MAIN ST.					
14. FATHER'S NAME First JOHN			Middle L			Last HAHNE			15. MOTHER'S MAIDEN NAME First MARY			Middle A			Last TALLEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT JOHN L HELLER					Address 128 W. MAIN ST. HANCOCK MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4120 MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carotid Artery Stenosis Hemiparesis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiac Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 wks																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 2/8, 1968, to 4/25, 1968, that (I) (we) last saw the deceased alive on 4/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE D.M. Shaffer M.D.										22c. DATE SIGNED 4/27/68						
22d. PHYSICIAN'S NAME (Type) L.M. SHAPPER										22e. ADDRESS 14 Main St Hancock Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4.28.58			23c. NAME OF CEMETERY OR CREMATORY EPISCOPAL			23d. LOCATION (City or Town) (County) (State) HANCOCK WASHINGTON MD.							
24. FUNERAL DIRECTOR Howard J. Stone Hancock Md										25a. REC'D BY REGISTRAR DATE MAY 01 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			

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WASHINGTON, D.C. 20540

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

WASHINGTON, D.C. 20540

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

WASHINGTON, D.C. 20540

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DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

WASHINGTON, D.C. 20540

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DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

WASHINGTON, D.C. 20540

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06262		06268	
1. DECEASED-NAME (Type or print) Edgar 7 Hoffmeier		2a. DATE OF DEATH Month 4 Day 17 Year 68	
3. SEX M	4. RACE W	5. DATE OF BIRTH 7-6-1879	6. AGE (In years lost birthday) 88 YRS.
7a. BIRTHPLACE (State or foreign country) Pa		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH Washington		9d. Md.	
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homeewood Church Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clergyman	12b. KIND OF BUSINESS OR INDUSTRY Pastor
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last Emelius - Hoffmeier		15. MOTHER'S MAIDEN NAME First Middle Last Lucinda Defibaugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 215-36-6515A	
17. INFORMANT mak gwagner		Address 2750 Va Ave Williamsport, 21795	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive CV Dis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 8 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 22 , 1965, to 4-17 , 1968, that (I) (we) last saw the deceased alive on 4-17 , 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert P. Conrad, MD		22c. DATE SIGNED 4-17-68	
22d. PHYSICIAN'S NAME (Type) Robert P. Conrad		22e. ADDRESS 137 W. Washington Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-20-1968	23c. NAME OF CEMETERY OR CREMATORY Glade Cemetery	23d. LOCATION (City or Town) (County) (State) Walkersville, Frederick, Md.
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR DATE APR 19 1968	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06269

1. DECEASED-NAME (Type or print)		First EDNA		Middle ELIZA		Last HOOVER		2a. DATE OF DEATH Month 4 / Day 24 / Year 68			2b. HOUR A 11:40				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 18, 1881			6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.									
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 426 NORTH POTOMAC STREET							
14. FATHER'S NAME First A.		Middle ELDER		Last HOOVER		15. MOTHER'S MAIDEN NAME First MARY		Middle ALICE		Last GAVER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO. NOT AVAILABLE		17. INFORMANT MRS. ALICE H. BELL.		426 Address N. POTOMAC ST. HAGERSTOWN, MARYLAND.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 Massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of pelvic veins DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of sigmoid colon with metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One minute 3 days 18 months										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1533					
19a. DATE OF OPERATION 3/28/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid obstruction				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 3/27, 1968, to 4/24, 1968, that (I) (we) last saw the deceased alive on 4/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Omar D. Sprecher, Jr. M.D.										22c. DATE SIGNED 4/25/68		22d. PHYSICIAN'S NAME (Type) O. D. SPRECHER, M.D.		22e. ADDRESS 1229 RAVENWOOD HEIGHTS, HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/27/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN, WASH. CO. MD.		(County)		(State)					
24. FUNERAL DIRECTOR Helen L. Edulberg				25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First MILES			Middle HORST			Last HORST			2a. DATE OF DEATH Month / Day / Year 4 / 5 / 68			2b. HOUR 9:00 M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MAY 25, 1891			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.								
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED EMPLOYEE			12b. KIND OF BUSINESS INDUSTRY U.S. GOVERN-								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNSYLVANIA			13b. COUNTY LEBANON			13c. CITY OR TOWN LEBANON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 103 EAST WALNUT STREET					
14. FATHER'S NAME First URIAH			Middle HORST			Last HORST			15. MOTHER'S MAIDEN NAME First EMMA			Middle L			Last OBERHOLTZER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			(If yes give war or dates of service) ***			16b. SOCIAL SECURITY NO. NOT AVAILABLE			17. INFORMANT 103 EAST WALNUT STREET, MRS. KATHRYN R. HORST, LEBANON, PENNSYLVANIA.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery dis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1-2 hrs. years.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio. Dis.</u> <u>Cerebral thrombosis.</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (myself) attended the deceased from <u>5 April 1968</u> , to <u>5 April 1968</u> , that (I) (we) lost the deceased alive on <u>5 April 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Richard T. Binford</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED APRIL 6, 1968								
22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.			22e. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4/9/68			23c. NAME OF CEMETERY OR CREMATORY SCHAEFFERTOWN CEMETERY, HEIDELBERG TWP. LEB. CO. PA.			23d. LOCATION (City or Town) (County) (State)								
24. FUNERAL DIRECTOR <u>Nelson L. Eichberger</u>			ADDRESS ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND.			25a. REC'D BY REGISTRAR DATE APR 9 - 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

CERTIFICATE OF STATE

1910

Blank certificate form with horizontal lines for text entry.

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby Girl		First Middle Last Hott		2a. DATE OF DEATH April Month Day 10 Year 68		2b. HOUR PM 12:50	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 9 1968		6. AGE (In years last birthday) YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Washington Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington County	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If hospital, give street address) Hospital Washington Co.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Sharpsburg RFD 1		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Ronnie Hott		15. MOTHER'S MAIDEN NAME First Middle Last Mary Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Ronnie Hott Sharpsburg Md. RFD #1					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7769 Atelectasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7625							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 9, 1968 , to April 10, 1968 , that (I) (we) last saw the deceased alive on April 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE F.D. Dove Jr. M.D.		22c. DATE SIGNED 4/10/68		22d. PHYSICIAN'S NAME (Type) F.D. Dove Jr. M.D.			
22e. ADDRESS Hagerstown, Maryland		23a. BURIAL, CREMATION, or other disposition (Specify) Burial					
23b. DATE April 12-68		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Near Tilghmanton, Washington, Md.			
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Maryland		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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Figure 1. Study design.

57-1047-1A-1000

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1994-1995 1996-1997 1998-1999 2000-2001 2002-2003 2004-2005 2006-2007 2008-2009 2010-2011 2012-2013 2014-2015 2016-2017 2018-2019 2020-2021 2022-2023 2024-2025 2026-2027 2028-2029 2030-2031 2032-2033 2034-2035 2036-2037 2038-2039 2040-2041 2042-2043 2044-2045 2046-2047 2048-2049 2050-2051 2052-2053 2054-2055 2056-2057 2058-2059 2060-2061 2062-2063 2064-2065 2066-2067 2068-2069 2070-2071 2072-2073 2074-2075 2076-2077 2078-2079 2080-2081 2082-2083 2084-2085 2086-2087 2088-2089 2090-2091 2092-2093 2094-2095 2096-2097 2098-2099 2100-2101 2102-2103 2104-2105 2106-2107 2108-2109 2110-2111 2112-2113 2114-2115 2116-2117 2118-2119 2120-2121 2122-2123 2124-2125 2126-2127 2128-2129 2130-2131 2132-2133 2134-2135 2136-2137 2138-2139 2140-2141 2142-2143 2144-2145 2146-2147 2148-2149 2150-2151 2152-2153 2154-2155 2156-2157 2158-2159 2160-2161 2162-2163 2164-2165 2166-2167 2168-2169 2170-2171 2172-2173 2174-2175 2176-2177 2178-2179 2180-2181 2182-2183 2184-2185 2186-2187 2188-2189 2190-2191 2192-2193 2194-2195 2196-2197 2198-2199 2200-2201 2202-2203 2204-2205 2206-2207 2208-2209 2210-2211 2212-2213 2214-2215 2216-2217 2218-2219 2220-2221 2222-2223 2224-2225 2226-2227 2228-2229 2230-2231 2232-2233 2234-2235 2236-2237 2238-2239 2240-2241 2242-2243 2244-2245 2246-2247 2248-2249 2250-2251 2252-2253 2254-2255 2256-2257 2258-2259 2260-2261 2262-2263 2264-2265 2266-2267 2268-2269 2270-2271 2272-2273 2274-2275 2276-2277 2278-2279 2280-2281 2282-2283 2284-2285 2286-2287 2288-2289 2290-2291 2292-2293 2294-2295 2296-2297 2298-2299 2300-2301 2302-2303 2304-2305 2306-2307 2308-2309 2310-2311 2312-2313 2314-2315 2316-2317 2318-2319 2320-2321 2322-2323 2324-2325 2326-2327 2328-2329 2330-2331 2332-2333 2334-2335 2336-2337 2338-2339 2340-2341 2342-2343 2344-2345 2346-2347 2348-2349 2350-2351 2352-2353 2354-2355 2356-2357 2358-2359 2360-2361 2362-2363 2364-2365 2366-2367 2368-2369 2370-2371 2372-2373 2374-2375 2376-2377 2378-2379 2380-2381 2382-2383 2384-2385 2386-2387 2388-2389 2390-2391 2392-2393 2394-2395 2396-2397 2398-2399 2400-2401 2402-2403 2404-2405 2406-2407 2408-2409 2410-2411 2412-2413 2414-2415 2416-2417 2418-2419 2420-2421 2422-2423 2424-2425 2426-2427 2428-2429 2430-2431 2432-2433 2434-2435 2436-2437 2438-2439 2440-2441 2442-2443 2444-2445 2446-2447 2448-2449 2450-2451 2452-2453 2454-2455 2456-2457 2458-2459 2460-2461 2462-2463 2464-2465 2466-2467 2468-2469 2470-2471 2472-2473 2474-2475 2476-2477 2478-2479 2480-2481 2482-2483 2484-2485 2486-2487 2488-2489 2490-2491 2492-2493 2494-2495 2496-2497 2498-2499 2500-2501 2502-2503 2504-2505 2506-2507 2508-2509 2510-2511 2512-2513 2514-2515 2516-2517 2518-2519 2520-2521 2522-2523 2524-2525 2526-2527 2528-2529 2530-2531 2532-2533 2534-2535 2536-2537 2538-2539 2540-2541 2542-2543 2544-2545 2546-2547 2548-2549 2550-2551 2552-2553 2554-2555 2556-2557 2558-2559 2560-2561 2562-2563 2564-2565 2566-2567 2568-2569 2570-2571 2572-2573 2574-2575 2576-2577 2578-2579 2580-2581 2582-2583 2584-2585 2586-2587 2588-2589 2590-2591 2592-2593 2594-2595 2596-2597 2598-2599 2600-2601 2602-2603 2604-2605 2606-2607 2608-2609 2610-2611 2612-2613 2614-2615 2616-2617 2618-2619 2620-2621 2622-2623 2624-2625 2626-2627 2628-2629 2630-2631 2632-2633 2634-2635 2636-2637 2638-2639 2640-2641 2642-2643 2644-2645 2646-2647 2648-2649 2650-2651 2652-2653 2654-2655 2656-2657 2658-2659 2660-2661 2662-2663 2664-2665 2666-2667 2668-2669 2670-2671 2672-2673 2674-2675 2676-2677 2678-2679 2680-2681 2682-2683 2684-2685 2686-2687 2688-2689 2690-2691 2692-2693 2694-2695 2696-2697 2698-2699 2700-2701 2702-2703 2704-2705 2706-2707 2708-2709 2710-2711 2712-2713 2714-2715 2716-2717 2718-2719 2720-2721 2722-2723 2724-2725 2726-2727 2728-2729 2730-2731 2732-2733 2734-2735 2736-2737 2738-2739 2740-2741 2742-2743 2744-2745 2746-2747 2748-2749 2750-2751 2752-2753 2754-2755 2756-2757 2758-2759 2760-2761 2762-2763 2764-2765 2766-2767 2768-2769 2770-2771 2772-2773 2774-2775 2776-2777 2778-2779 2780-2781 2782-2783 2784-2785 2786-2787 2788-2789 2790-2791 2792-2793 2794-2795 2796-2797 2798-2799 2800-2801 2802-2803 2804-2805 2806-2807 2808-2809 2810-2811 2812

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AND (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) MORRIS (NMN) KLEIN					2a. DATE OF DEATH Month April Day 5 Year 1968			2b. HOUR 9:15 AM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH Dec 10 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Meat cutter		12b. KIND OF BUSINESS OR INDUSTRY butcher			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Hunter Hill Apts	
14. FATHER'S NAME First Herman Middle Klein Last Klein				15. MOTHER'S MAIDEN NAME First Sarah Middle (no record) Last (no record)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO. 218-30-9607		17. INFORMANT Address Mrs Florence Klein Hunter Hill Apt					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month April Day 5 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. --- City or Town --- County --- State ---					
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1968 , to April 5, 1968 , that (I) (we) last saw the deceased alive on April 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Drey				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 5 - 68	
22d. PHYSICIAN'S NAME (Type) S. DREY				22e. ADDRESS ROSENSTEIN FURNITURE MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/7/68		23c. NAME OF CEMETERY OR CREMATORY B'nai Abraham Cemetery		23d. LOCATION (City or Town) Hagerstown (County) Washington (State) Md			
24. FUNERAL DIRECTOR Andrew K. Coffman				FUNERAL HOME Furnish Funeral Home Inc		25a. REC'D BY REGISTRAR APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

Information
Center & Research Bureau

✓
yes

✓
yes 28 April 61

✓
yes 28 April 61
2. Day / NOVEMBER
FURNITURE CO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) Maxwell Floyd Kretsinger			2a. DATE OF DEATH Month April Day 18 Year 1968			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 15, 1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Orcharist		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Chewsville, Wash. County		
14. FATHER'S NAME First Middle Last Frank H. Kretsinger			15. MOTHER'S MAIDEN NAME First Middle Last Emma Beard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 215-36-6619		17. INFORMANT Mrs. Beulah Hoover Smithsburg, Md			Address R.#3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hrs. 10 yrs. 10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 260X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-14 , 19 68 , to 4-18 , 19 68 , that (I) (was) last saw the deceased alive on 4-18 , 19 68 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.											
22b. SIGNATURE Charles F. Hess M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-19-68				
22d. PHYSICIAN'S NAME (Type) Charles F. Hess					22e. ADDRESS Smithsburg, Maryland.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 21/68		23c. NAME OF CEMETERY OR CREMATORY Mausoleum		23d. LOCATION (City or Town) (County) (State) Smithsburg Maryland					
24. FUNERAL DIRECTOR Andrew R. Coffman Funeral Home Inc. Hagerstown, Maryland.					25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

Maxwell	Elroy	Richardson	April 16, 1938
Male	White	June 15, 1939	65
Washington	U.S.A.	Washington	
Hagerstown	Washington County Hospital	Former	Operated
Maryland	Washington Hagerstown	x Chewsville, Wash. County	
Frank H. Richardson	Elroy	June 15, 1939	65
218-36-0019	Mrs. Boudie Hoover	Washington	
None			
Charles E. Neal	April	Washington	
April 21/38	Washington		
Robert A. Goldman	Washington		
Hagerstown, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) BABY GIRL LEIGHTY			2a. DATE OF DEATH Month APRIL Day 15 Year 68			2b. HOUR 11:50 PM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH APRIL 15, 1968		6. AGE (In years last birthday) YRS. MONTHS DAYS 1 35		IF UNDER 1 YEAR MONTHS DAYS 1 35	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 GARLINGER AVENUE	
14. FATHER'S NAME First Middle Last EDWARD BART BOECKMANN			15. MOTHER'S MAIDEN NAME First Middle Last PATRICIA ANN MYERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MOTHER		Address 24 GARLINGER AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 777X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-15 , 19 68 , to 4-15 , 19 68 , that (I) (we) last saw the deceased alive on 4-15 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. M. Mandell						22c. DATE SIGNED 4-16-68		22d. PHYSICIAN'S NAME (Type) DR. A. M. MANDELL	
22e. ADDRESS HAGERSTOWN, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APRIL 16, 1968		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON COUNTY HOSPITAL HAGERSTOWN, MARYLAND		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR John Schaffer, Adm.		ADDRESS Wash Co Hosp		25a. REC'D BY REGISTRAR DATE APR 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06275

1. DECEASED NAME (Type or print) CRYSTAL ANN LEWIS			2a. DATE OF DEATH Month April Day 15 Year 1968			2b. HOUR 6:55 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 14-1968		6. AGE (In years last birthday) 0 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN SMITHSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First ROY Middle LEE Last LEWIS		15. MOTHER'S MAIDEN NAME First MARY Middle LOU Last CRIM		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. ---	
17. INFORMANT MOTHER		Address ROUTE 2 BOX 62 SMITHSBURG, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Pulmonary Atelectasis 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) marked Immaturity and Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) ---		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7625							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald E. Keyser		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-68			
22d. PHYSICIAN'S NAME (Type) DR. R.E. KEYSER		22e. ADDRESS HAGERSTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.	
24. FUNERAL DIRECTOR Wm. C. Wood		ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DA APR 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Abstract

[Faint handwritten notes at the bottom of the page]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove extra papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Anna Matilda Lindstrom</i>			2a. DATE OF DEATH Month Day Year <i>Apr 2 1968</i>		2b. HOUR <i>10:30 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Sept. 1, 1882</i>		6. AGE (In years lost birthday) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Sweden</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>WASHINGTON</i> Md.		
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Wash. D.C.</i>	13b. COUNTY <i>Dist. of Columb.</i>	13c. CITY OR TOWN <i>Wash. D.C.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>5522 Border Drive</i>	
14. FATHER'S NAME First Middle Last <i>Karl J. Pearsson</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Johanna ?</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Robert L. Christie Same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, general</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i> <i>years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201 Bilateral lobular pneumonia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>11-1-67</i> , to <i>4-2-1968</i> , that (I) (we) last saw the deceased alive on <i>4-2-68</i> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edwin G. Riley</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>4-3-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Edwin G. Riley</i>		22e. ADDRESS <i>1500 Penna, Hagerstown, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/8/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Orion, Ill.</i>	
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm</i> ADDRESS <i>4308 Suitland Road, Suitland, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>APR 8 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-15-64
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last LESLIE LAWRENCE LUGAR					2a. DATE OF DEATH Month Day Year April 5 1968			2b. HOUR 12.30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb 22 1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Martin Manor Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telegraph Operator		12b. KIND OF BUSINESS OR INDUSTRY R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 148 So Mulberry St	
14. FATHER'S NAME First Middle Last No Record				15. MOTHER'S MAIDEN NAME First Middle Last No Record						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 572-02-0255		17. INFORMANT Address Mrs Mary B. Lugar 148 So Mulberry St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490x (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Cardio-Vascular Disease - Coronary Arteriosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 18 Sept. 1963 , to April 5, 1968 , that (I) (we) last saw the deceased alive on April 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W.N. FENDER M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6 April 1968				
22d. PHYSICIAN'S NAME (Type) W.N. FENDER				22e. ADDRESS 218 N. Potomac St. Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/8/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md				
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR APR 9 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the work done on each project, and a summary of the results obtained. The second part of the report is a detailed description of the work done on each project. It includes a list of the objectives of each project, a description of the methods used, and a summary of the results obtained. The third part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the work done on each project, and a summary of the results obtained. The fourth part of the report is a detailed description of the work done on each project. It includes a list of the objectives of each project, a description of the methods used, and a summary of the results obtained. The fifth part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the work done on each project, and a summary of the results obtained. The sixth part of the report is a detailed description of the work done on each project. It includes a list of the objectives of each project, a description of the methods used, and a summary of the results obtained. The seventh part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the work done on each project, and a summary of the results obtained. The eighth part of the report is a detailed description of the work done on each project. It includes a list of the objectives of each project, a description of the methods used, and a summary of the results obtained. The ninth part of the report is a summary of the work done during the year. It includes a list of the projects completed, a description of the work done on each project, and a summary of the results obtained. The tenth part of the report is a detailed description of the work done on each project. It includes a list of the objectives of each project, a description of the methods used, and a summary of the results obtained.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A.M. P.M.			
PHYLLIS VIRGINIA MARTIN						April 25 1968			10:30			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Female		White		June 21, 1914			53 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U.S.A.				Washington Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington Cty Hospital		Housewife		Own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Maryland		Washington Hagerstown				208 Alexander St.						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
John Calvin McNamee						Wavey Lee Youngblood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT						
no			None			William V. Martin, 208 Alexander St						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior Wall Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 7-10 days unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/24, 1968, to 4/25, 1968, that (I) (we) last saw the deceased alive on 4/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE William O. Rexrode M.D.			22c. DATE SIGNED 4/26/68									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
William O. Rexrode			145 SOUTH PROSPECT STREET									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)			
Burial			4/29/68		Rose Hill Cemetery		Hagerstown, Wash.		Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
A. K. Coffman Funeral Home, Inc			Hagerstown, Md.			Charles Judge						
DATE			APR 30 1968									

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Washington City Hospital
208 Alexander St.

John	Calvin	James	Henry	Joe	Youngblood
on	--	None	William V. Smith, 505	100	100

K. Coleman Funeral Home, Inc.,
Baltimore, Md.
4/22/68 Rose Hill Cemetery
Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Ralph Manon Martin			2a. DATE OF DEATH Month Day Year April 18 1968		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 23, 1905		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Chambersburg, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Funeral Dir. & Embalmer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1025 Fairview Road
14. FATHER'S NAME First Middle Last David nmn Martin			15. MOTHER'S MAIDEN NAME First Middle Last Elsie Manon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 186-01-0723		17. INFORMANT Address Md. Mrs. Ruth Martin 1025 Fairview Rd. Hagerstown.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-15 , 1968, to 4-18 , 1968, that (I) (we) last saw the deceased alive on 4-18 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert P. Connor, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-19-68	
22d. PHYSICIAN'S NAME (Type) Robert P. Connor				22e. ADDRESS 137 W. Washington Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/21/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
24. FUNERAL DIRECTOR Wm. C. Horne		24b. ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE Apr 23 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles J. J.	

MEDICAL CERTIFICATION

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Marvin	Middle Clayton	Last Mason	2a. DATE OF DEATH Apr Month 18 Day 1968 Year		2b. HOUR A 6:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4/6/05		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Night watchman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 234 West Side Ave.	
14. FATHER'S NAME First -		Middle -		Last -		15. MOTHER'S MAIDEN NAME First Martha		Middle - Last -	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO. 217-05-9568		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (did not) attended the deceased from 10/2/67 , 19 67 , to 4/18 , 19 68 , that (I) (was) last saw the deceased alive on April 18 , 19 68 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (not) view the body after death.									
22b. SIGNATURE Domingo A. Garcia								22c. DATE SIGNED 4/18/68	
22d. PHYSICIAN'S NAME (Type) Domingo A. Garcia, M.D.		22e. ADDRESS Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown							
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE April 20, 68		23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or Town) (County) (State) Hancock Wash. Md.			
24. FUNERAL DIRECTOR Donald E. Thompson				25a. REC'D BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Lester First James Middle Mathna Last</i>						2a. DATE OF DEATH <i>April</i> Month <i>27</i> Day <i>1968</i> Year			2b. HOUR <i>5:10 P.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 6, 1908</i>		6. AGE (In years last birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Franklin Co. Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>WASHINGTON</i> Md.					
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Machine Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Contractor</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>441 N. Prospect St.</i>			
14. FATHER'S NAME First Middle Last <i>John Samuel Mathna</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Katie Florence Simons</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>217-10-3378</i>		17. INFORMANT Address <i>R.E. Mathna 919 W. Washington St. Hagerstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1621</i> <i>Carcinoma of lung with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>163x</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edwin G. Riley M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <i>4-27-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Edwin G. Riley M.D.</i>						22e. ADDRESS <i>W.M. State Hospital Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/30/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>					
24. FUNERAL DIRECTOR <i>Wm. G. Horst</i> ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>				25a. DATE <i>APR 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

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April 21

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
STANLEY LE ROY McCOY						April 6 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Aug 2 1889		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash County Hospital			Cabinet Maker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md			Washington Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1804 W. Washington St		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Benjamin McCoy			Amanda Shank						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					Mrs Mary H. McCoy 1804 W. Washington St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardio Vascular Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 days</u> <u>6 hrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>443 X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan -</u> , 19 <u>62</u> to <u>April 6</u> , 19 <u>62</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 5</u> , 19 <u>62</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22b. SIGNATURE <u>Chas A. Hoffman</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <u>4/8/62</u>	
22d. PHYSICIAN'S NAME (Type) <u>Chas A. Hoffman</u>								22e. ADDRESS <u>214 N. Potomac St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/9/68		Rest Haven Cemetery		Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS <u>Andrew K. Coffman Funeral Home Inc</u>					25a. REC'D BY REGISTRAR DATE <u>APR 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

06278

CERTIFICATE OF DEATH

06282

03332

1028

RECEIVED

DATE: 10/10/1961

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1961

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1961

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10/10/1961

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06277

CERTIFICATE OF DEATH

06283

1. DECEASED-NAME (Type or print) John Harold Mellott			2a. DATE OF DEATH April 29, 1968 Year			2b. HOUR 7:00	
3. SEX male		4. RACE white		5. DATE OF BIRTH Aug. 31, 1910		6. AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.		13b. COUNTY Fulton		13c. CITY OR TOWN Big Cove Tannery		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last Jacob W. Mellott					
15. MOTHER'S MAIDEN NAME First Middle Last Margaret Barmont		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO.		17. INFORMANT Address Helen Mellott, Big Cove Tannery, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure 57/19 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 58/10 (b) dehydrated / uremia / Autopsy / complete DUE TO, OR AS A CONSEQUENCE OF (c) Hepato-renal syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Portal cirrhosis, Chronic bronchitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Apr 20, 1968 , to Apr 29, 1968 , that (I) (we) last saw the deceased alive on Apr 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles C. Spencer MD.				22c. DATE SIGNED 4-30-68		22d. PHYSICIAN'S NAME (Type) Charles C. Spencer	
22e. ADDRESS 145 S. Prospect St Hagerstown				23a. BURIAL, CREMATION, REMOVAL Burial			
23b. DATE 5-2-68		23c. NAME OF CEMETERY OR CREMATORY Sidling Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Licking Creek, Penna.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE MAY 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

detached central history complete

Fonte Remo Tullio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06284

1. DECEASED-NAME (Type or print) Christian Frederick Meyer			2a. DATE OF DEATH Month April Day 29 Year 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 27, 1881		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Eisenstat Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Blacksmith		12b. KIND OF BUSINESS OR INDUSTRY Retierd			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Mt. Aetna Road	
14. FATHER'S NAME First Middle Last Martin Meyer			15. MOTHER'S MAIDEN NAME First Middle Last Anna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-12-8102		17. INFORMANT Mrs Sarah K. Meyer		Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days 10 Yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-1, 1968 , to 4-29, 1968 , that (I) (we) last saw the deceased alive on 4-28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles F. Hess M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-20-68	
22d. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				22e. ADDRESS Smithsburg (Wash) Maryland					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE May 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Weltys Cemetery		23d. LOCATION (City or Town) (County) (State) Near Smithsburg, Md.			
24. FUNERAL DIRECTOR Andrew J. Coffman Funeral Home Inc. Hagerstown, Maryland.				25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1988

EXHIBIT OF RECORD

483

Christian Frederick Meyer April 29, 1908

White Aug. 27, 1881

Washington U.S.A. Germany

Washington County, Md. Blacksmith
Washington County, Md. Blacksmith

Washington County, Md. Blacksmith
213-11-8102 Mr. James H. Meyer
Washington, Md.

Charles E. Hess W.D. Smithburg (wash) Maryland
May 2, 1908 W.D. Smithburg, Md.

Andrew K. Colman Home Inc.
Washington, Maryland

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06285

1. DECEASED-NAME (Type or print) First Middle Last GEORGE ERNEST MICHAEL			2a. DATE OF DEATH Month 12 Day 1968 APRIL 12 1968		2b. HOUR 6P. M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10/21/1880		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH RURAL HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT#3		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) RETIRED FARMER	
12b. KIND OF BUSINESS OR INDUSTRY OWN FARM		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON	
13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER RT#3	
14. FATHER'S NAME First Middle Last ANDREW W. MICHAEL			15. MOTHER'S MAIDEN NAME First Middle Last ELLA PRITCHARD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 236-60-3390		17. INFORMANT MRS. ERNESTINE HART HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalised Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 60 , to 4/12 , 19 68 , that (I) (we) last saw the deceased alive on 3/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert V. Campbell		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/13/68	
22d. PHYSICIAN'S NAME (Type) Robert V. L. Campbell		22e. ADDRESS HAGERSTOWN Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/16/68		23c. NAME OF CEMETERY OR CREMATORY MT. ZION E.U.B. CH.	
23d. LOCATION (City or Town) MOGAN (State) W. VA.		23e. SPHORS CROSS RD.			
24. FUNERAL DIRECTOR W. J. Korman, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 19 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY

RE: [Illegible Title]

1. [Illegible Text]

2. [Illegible Text]

3. [Illegible Text]

4. [Illegible Text]

5. [Illegible Text]

6. [Illegible Text]

7. [Illegible Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06286

1. DECEASED-NAME (Type or print) NAOMI		First MAY		Middle MIDDLE		Last LEKAUFF		2a. DATE OF DEATH APRIL 11 Month 11 Day 1968		2b. HOUR 11 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5/22/1893		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 60 E. WASHINGTON ST.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 60 E. WASHINGTON ST.					
14. FATHER'S NAME First ROBERT Middle WILLIAM Last SUPINGER		15. MOTHER'S MAIDEN NAME First ALBERTA Middle C. Last MILLER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. DOROTHY BECKLEY WILLIAMSPORT MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Short Indefinite											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 15 , 19 61 , to April 11 , 19 68 , that (I) (we) lost the deceased on March 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. B. Kneisley M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 12, 1968					
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22e. ADDRESS 148 West Washington Street Hagerstown, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/13/68		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR W. J. Norment Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Sarah Jane Miner		2a. DATE OF DEATH Month Day Year April 21, 1968		2b. HOUR A 3:35 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH October 7, 1942		6. AGE (In years last birthday) 25 YRS.
7a. BIRTHPLACE (State or foreign country) Franklin Co., Pa.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington County Md.				
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania	13b. COUNTY Franklin	13c. CITY OR TOWN Mont Alto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last Wilson M. Shaffer		15. MOTHER'S MAIDEN NAME First Middle Last Jane Monn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 198-34-6203	17. INFORMANT Address Ronald C. Miner Mont Alto Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u> 2381 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain stem tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237X				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
19a. DATE OF OPERATION 4-13-68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Increased intracranial pressure	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 4-11-68, 19__, to 4-21-68, 19__, that (I) (we) last saw the deceased alive on 4-20-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE A. F. Abdullah DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED April 24, 1968
22d. PHYSICIAN'S NAME (Type) A. F. ABDULLAH, M. D.		22e. ADDRESS 318 N. Potomac St., Hagerstown, Md. 21740		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/24/68	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	23d. LOCATION (City or Town) (County) (State) Waynesboro #1 Franklin Pa.	
24. FUNERAL DIRECTOR Walter Z. Grove		25a. REC'D BY REGISTRAR DA APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) Myrtle		First E.		Middle Moser		Last		2a. DATE OF DEATH Month April Day 18 , Year 1968		2b. HOUR 3:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 8, 1881		6. AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS 2 DAYS 8		IF UNDER 24 HRS. HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) Myersville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garlock Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rfd. 2 (Mapleville)			
14. FATHER'S NAME First Lawrence		Middle Easterday		Last		15. MOTHER'S MAIDEN NAME First Ellen		Middle Herr		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No.		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-52-2137		17. INFORMANT Address Mrs. Shirley Shifler, Rfd. 2 Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive CV Dis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 8 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1967 , to 4-16 , 1968, that (I) (we) last saw the deceased alive on 4-14 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert P. Conrad MD		22c. DATE SIGNED 4-17-68		22d. PHYSICIAN'S NAME (Type) Robert P. Conrad		22e. ADDRESS 137 W. Washington Hagerstown, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-19-68		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro Wash. Co., Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DATE APR 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06283 CERTIFICATE OF DEATH 06289									
1. PLACE OF DEATH a. COUNTY Washington Hagerstown MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 4 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 31 Fenton Ave.				
3. NAME OF DECEASED (Type or print) George Franklin Murray					4. DATE OF DEATH Month April Day 20 Year 1968				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1902		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Washington Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George W. Murray					14. MOTHER'S MAIDEN NAME Bessie Bell Bowers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Daisy Murray Williamsport Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis - Paracolon, Proteus 011.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Super-imposed on pulmonary tuberculosis, moderately advanced bilateral, questionably active (c) active PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm, thoracic aorta, auricular fibrillation 002.1									INTERVAL BETWEEN ONSET AND DEATH 13 days 13 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 15 , 19 68 , to April 20 , 19 68 , that (I) (we) last saw the deceased alive on April 20 , 19 68 , and that death occurred at 12:20 PM from the causes and on the date stated above.									
22a. SIGNATURE W. T. Layman, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 22, 1968		
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.					22d. ADDRESS 100 Prof. Arts Building, Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23, 68		23c. NAME OF CEMETERY OR CREMATORY Shanktown		23d. LOCATION (City, town or county) (State) Shanktown Wash. Md.			
24. FUNERAL DIRECTOR Donald E. Thompson					ADDRESS Thompson Funeral Home Clear Spring, Md.		25a. REC'D BY REGISTRAR APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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Hagerstown

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Hagerstown

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Williamstown Maryland

Washington County Hospital 31 Penion Ave.

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Murray

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White

Aug. 27, 1902

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Washington Maryland U.S.A.

George W. Murray

Bessie Bell Bowers

No

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Mrs. Daisy Murray

Williamstown Md.

Pneumonia - Paracolon, Proton

1902

Super-imposed on pulmonary tuberculosis, moderately advanced bilateral, questionably active

Aneurysm, thoracic aorta, aneurysmal dilatation

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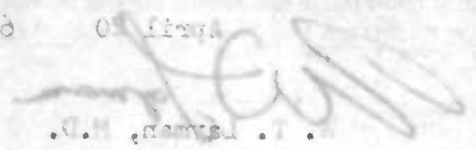
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100 Prof. Arts Building, Hagerstown, Md.

H. T. Layman, M.D.



Burial April 23, 08 Shanktown

Shanktown Wash. Md.

Thompson Funeral Home Clear Spring, Md. APR 23 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Jennie Amelia Neikirk</i>			2a. DATE OF DEATH Month Day Year <i>April 8, 1968</i>			2b. HOUR <i>8¹⁰ P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Feb 8, 1971</i>		6. AGE (In years last birthday) <i>97</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Rehersville, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Williamsport Sanitarium</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1264 Guilford Rd.</i>			
14. FATHER'S NAME First Middle Last <i>Hezekiah Easton</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Susan Skifer</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No.		16b. SOCIAL SECURITY NO. <i>162-22-7035</i>		17. INFORMANT (Daughter) Address <i>Mrs Lenore Lehman 245 Phila Ave Penn.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>October 3, 1965</i> , to <i>April 6, 1968</i> , that (I) <i>did</i> last saw the deceased alive on <i>April 6, 1968</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>did</i> (did not) view the body after death.									
22b. SIGNATURE <i>M.E. Byrkit</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-8-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit M.D.</i>		22e. ADDRESS <i>28 West Potomac St. Williamsport Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-10-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Boonsboro Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Boonsboro, Wash. Co., Md.</i>			
24. FUNERAL DIRECTOR <i>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</i>				25a. REC'D BY REGISTRAR <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06285

06291

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>2 wks.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilhelmina</u> Middle <u>(NMN)</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>9</u> Year <u>1968</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not known</u>
9. AGE (In years last birthday) <u>app. 80 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Reisner</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Hartman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not known</u>	
17. INFORMANT <u>Mr. Russell Nelson, St. James, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4129 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure blood form 3 wks</u> (c) <u>retrocardiac heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u> <u>cardiomyopathy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>68</u> , to <u>April 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 9</u> , 19 <u>68</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edson B. Moody</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edson B. Moody</u>		22d. ADDRESS <u>363 S. Cleveland Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 12, 68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City or Town) (County) (State) <u>Apr. Twp. Fulton Co. Pa.</u>	
24. FUNERAL DIRECTOR <u>Mr. Lüniger</u>		25a. REC'D BY REGISTRAR <u>APR 16 1968</u>	
ADDRESS <u>Mercersburg, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1922

CERTIFICATE OF ANALYSIS

1922

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a detailed report or analysis.]

ANALYST: *[illegible]*
DATE: *[illegible]*
PLACE: *[illegible]*
BY: *[illegible]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington County, b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cascade				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Royer Road, Gardener Avenue				d. STREET ADDRESS Royer Road, Gardner Avenue			
3. NAME OF DECEASED (Type or print) First Roy Middle W. Last Newberry				4. DATE OF DEATH Month April Day 3 Year 19 68			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 1918	9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Army		10b. KIND OF BUSINESS OR INDUSTRY Criminal Investigator		11. BIRTHPLACE (County & State, or foreign country) Wilberton, Oklahoma		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Guy Newberry				14. MOTHER'S MAIDEN NAME Sarah Schneider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Feb 41 - Aug 63 565-12-3176		17. INFORMANT Ileen M. Newberry (wife) Address Royer Ave & Gardner Cascade, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 425X DUE TO Primary Myocardiopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 hours 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 4222						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 12-18, 19 67 , to April 12-18, 19 68 , that (I) (we) last saw the deceased alive on 10 March 19 68 , and that death occurred at P. M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert Davidson				22b. DATE SIGNED 3 April 1968		22c. PHYSICIAN'S NAME (Type) ROBERT DAVIDSON, CPT, MC	
22d. ADDRESS US Army Dispensary, Fort Ritchie, Md.				22e. ADDRESS US Army Dispensary, Fort Ritchie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8 APRIL 1968		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR Rivardi Funeral Home, Inc		24a. ADDRESS 2400 BELMONT AVE. N.W. WASHINGTON DC 20012		25a. REC'D BY REGISTRAR APR 9 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Harold Schneider

Feb 21 - Aug 21 203-12-3176

Boyer Ave & Gardner
Gardner, Ontario

Cardiac failure

Primary hyperparathyroidism

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ROBERT BAYLOR, CPT, MC

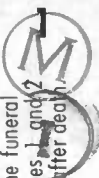
11 Army Hospital, Fort Lincoln, Mo.

[Handwritten notes and signatures at the bottom of the page, including "The Chief of the Staff" and "The Surgeon General"]

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last JOSEPH HARLAN PORTERFIELD					2a. DATE OF DEATH Month Day Year April 18 1968		2b. HOUR 2 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 23 1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS 9 25	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret'd Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER St. James College Road	
14. FATHER'S NAME First Middle Last Milton W. Porterfield			15. MOTHER'S MAIDEN NAME First Middle Last Ida Startzman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215-18-2733		17. INFORMANT Mrs. Lillian Porterfield		Address College Road Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF 5 years (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 26, 1968 , to April 18, 1968 , that (I) (we) lost saw the deceased alive on April 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. W. Ditto, Jr.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 19, 1968		
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.					22e. ADDRESS 215 W. Washington St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 20-68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md.			
24. FUNERAL DIRECTOR Albert Lewis Leaf Williamsport Maryland					25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin County	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Ritchie, Maryland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Blue Ridge Summit, Pennsylvania	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US Army Dispensary, Fort Ritchie, Md.		d. STREET ADDRESS P.O. Box 299, Ressler, La.	
3. NAME OF DECEASED (Type or print) First Wayne Middle Harvey Last Pottorff		4. DATE OF DEATH Month April Day 24 Year 1968	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 May 1914
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Air Force Officer		10b. KIND OF BUSINESS OR INDUSTRY US Air Force	
11. BIRTHPLACE (County & State, or foreign country) Springfield, Illinois		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Harvey Pottorff		14. MOTHER'S MAIDEN NAME Bertha Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 7 Apr 42-30 Oct 67 331-037-990	
17. INFORMANT Marie Pottorff (wife)		Address Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 5 Min. 7 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was not present) attended the deceased from July , 19 63 to April , 19 68 , that (I) (was not present) saw the deceased alive on 15 April , 19 68 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert Davidson		22b. DATE SIGNED 24 Apr 68	
22c. PHYSICIAN'S NAME (Type) ROBERT DAVIDSON, Captain, MC		22d. ADDRESS US Army Dispensary, Fort Ritchie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/68	
23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town or county) (State) Arlington, Arlington Co., Va.	
24. FUNERAL DIRECTOR Walter Y. Grove		25a. REC'D BY REGISTRAR APR 26 1968	
ADDRESS Waynesboro Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Georgia			First B. Middle B. Last Ramer			2a. DATE OF DEATH Apr Month 16 Day 68 Year			2b. HOUR 6:55AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 20, 1893			6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4601 Erie Street
14. FATHER'S NAME First John Middle R. Last Edmonds			15. MOTHER'S MAIDEN NAME First Anna Middle E. Last Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Eugene W. Ramer Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 436.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA c hemiplegia DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5d 3yr 10yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-19, 1965 , to Apr 16, 1968 , that (I) (we) last saw the deceased alive on Apr 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edwin G. Riley MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 4-16-68			
22d. PHYSICIAN'S NAME (Type) Edwin G Riley						22e. ADDRESS 1500 Penna, Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/18/68		23c. NAME OF CEMETERY OR CREMATORY Zion Episcopal Church		23d. LOCATION (City or Town) (County) (State) Hedgesville West Va.		
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Maryland						25a. REC'D BY REGISTRAR APR 22 1968 REGISTRAR'S SIGNATURE George			

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Generalized arteriosclerosis
CVA & peripheral
Atherosclerosis

82-224A

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Edward C. Rife
Chas. H. Rife MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Florida		Middle P.		Last Remsburg		2a. DATE OF DEATH Month April		
									Day 24		
									Year 1968		
3. SEX Female			4. RACE White		5. DATE OF BIRTH August 30, 1893			6. AGE (In years last birthday) 74		2b. HOUR 12:30A	
7a. BIRTHPLACE (State or foreign country) Bakersville, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Keedysville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9 N. Main St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9 N. Main St.		
14. FATHER'S NAME First Raleigh			Middle Poffenberger		Last Eakle		15. MOTHER'S MAIDEN NAME First Sarah				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No.			16b. SOCIAL SECURITY NO. 214-48-4154		17. INFORMANT Mr. W. Howard Remsburg, 9 N. Main St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thromboses</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County
											State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 27, 1968</u> , to <u>July 29, 1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>July 27, 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. W. LeVan M.D.</u>										22c. DATE SIGNED 4-24-68	
22d. PHYSICIAN'S NAME (Type) G. W. LeVan										22e. ADDRESS Boonsboro, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-26-68		23c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery			23d. LOCATION (City or Town) Bakersville, Wash. Co., Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md						25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06291

06297

1. DECEASED-NAME (Type or print) <i>Clifford Ellsworth Rice</i>			20. DATE OF DEATH <i>Apr</i> Month <i>27</i> Day <i>1968</i>			2b. HOUR <i>1:25 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 17, 1906</i>		6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Franklin, Co. Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>WASHINGTON</i> Md.			
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Route # 1</i>	
14. FATHER'S NAME First <i>Peter</i> Middle <i>H</i> Last <i>Rice</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Shank</i> Last <i>Shank</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>705-10-5434</i>		17. INFORMANT Address <i>Max E Rice 60 Peachtree Rd. N. Kingston, R.I.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepato-renal syndrome</i> <i>571.8</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>581.0</i> (b) <i>Portal cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5d several years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Bleeding esophageal varices, chronic pancreatitis-severe</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edwin G Riley MD</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <i>4-27-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Edwin G Riley</i>				22e. ADDRESS <i>1500 Penna, Hagerstown, Md 21746</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/30/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md</i>			
24. FUNERAL DIRECTOR <i>Wm C. West</i> ADDRESS <i>Rest Haven Funeral Chapel, Hagerstown, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

MEDICAL CERTIFICATION

Charles Ellsworth Rice Apr 27 1968

Washington

Office of the Surgeon General
Department of Health, Education and Welfare
Washington, D.C. 20540

Dear Sir:

Re: Hepato-renal syndrome
Portal cirrhosis
29 years

Bleeding esophageal varices, chronic pancreatitis-severe

+

Very truly yours,

Edwin C. Riley
1500 Penna, Hagerstown, Md 21740

4-27-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06298

1. DECEASED-NAME (Type or print) Samuel Cleveland Rice			2a. DATE OF DEATH Month April Day 6 Year 1968			2b. HOUR 12:00A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH February 15, 1888		6. AGE (In years lost birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Rohrersville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rohrersville		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Rohrersville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Rohrersville, Md.		14. FATHER'S NAME First Middle Last George W. Rice		15. MOTHER'S MAIDEN NAME First Middle Last Emma A. Bealer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO. 220-44-2338		17. INFORMANT Address Mrs. Janice Martz, Rohrersville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery dis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiac dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Information taken from Dr. Gerald Felan's records.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard T. Binford		22c. DATE SIGNED 7 April 68		22d. PHYSICIAN'S NAME (Type) Richard T. Binford			
22e. ADDRESS Hagerstown, Md.		22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-9-1968		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Rural Rohrersville, Wash, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 122 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Vincent Middle W. Last Robinson			2a. DATE OF DEATH Month April Day 30 Year 1968		2b. HOUR 5A. M
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 27, 1915		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Smithsburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Worker	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington	13c. CITY OR TOWN Rural	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D. 1
14. FATHER'S NAME First Roy Middle Robinson Last Robinson			15. MOTHER'S MAIDEN NAME First Marjorie Middle Warner Last Warner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-10-3704		17. INFORMANT Address Mrs. Joyce Wolfe Smithsburg Md., #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Rheumatic Heart Disease; Mitral Regurg. - Congestive Heart Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 12, 1968, to April 30, 1968, that (I) (we) last saw the deceased alive on April 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edson B. Moody		22c. DATE SIGNED 5/1/68		22d. PHYSICIAN'S NAME (Type) Edson B. Moody	
22e. ADDRESS 1145 S. Prospect St., Hagerstown Md.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/3/68		23c. NAME OF CEMETERY OR CREMATORY Bethel	
23d. LOCATION (City or Town) (County) (State) Frederick Md.					
24. FUNERAL DIRECTOR Walter Y. Grove		24b. ADDRESS Waynesboro Pa		25a. RECEIVED BY REGISTRAR MAY 6 1968	
25b. REGISTRAR'S SIGNATURE [Signature]					

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mcclure@u.washington.edu

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* 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 2689-2690, 2691-2692, 2693-2694, 2695-2696, 2697-2698, 2699-2700, 2701-2702, 2703-2704, 2705-2706, 2707-2708, 2709-2710, 2711-2712, 2713-2714, 2715-2716, 2717-2718, 2719-2720, 2721-2722, 2723-2724, 2725-2726, 2727-2728, 2729-2730, 2

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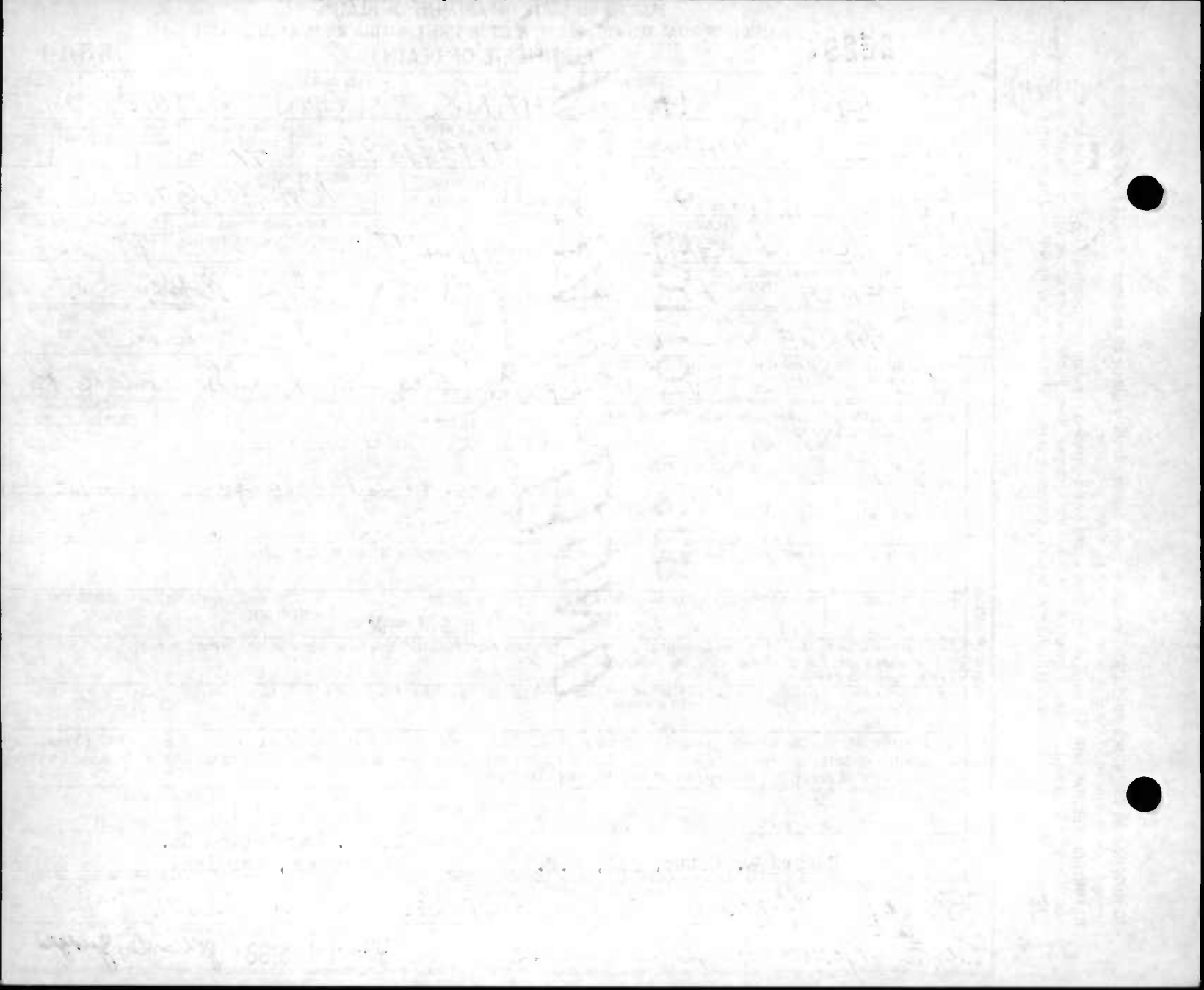
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) GUY First H. Middle S. Last SHANK						2a. DATE OF DEATH April Month 6 Day 1968 Year			2b. HOUR 7:45 P.			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 9/17/1896			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Co. Md.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garlock Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trucker			12b. KIND OF BUSINESS OR INDUSTRY Trucks	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.				13b. COUNTY Franklin		13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 615 WASH. ST.		
14. FATHER'S NAME First HARVEY Middle S. Last SHANK						15. MOTHER'S MAIDEN NAME First MARY J. Middle P. Last POTTER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) NO (If yes, give war or dates of service)				16b. SOCIAL SECURITY NO. 195-28-2317		17. INFORMANT Mrs. Ida Shank - Greencastle, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia 433.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerotic vascular DUE TO, OR AS A CONSEQUENCE OF (c) diarrhea + cerebral thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days 10-15 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 332X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Mar 21 , 19 68 , to Apr 6 , 19 68 , that (I) (we) last saw the deceased alive on Apr 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Edward W. Ditto, III DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 4-8-68						
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.						22e. ADDRESS 217 W. Washington St. Hagerstown, Maryland						
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE 4/9/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION (City or Town) (County) (State) Greencastle Pa.				
24. FUNERAL DIRECTOR A.E. Munch - Greencastle, Pa. ADDRESS						25a. REC'D BY REGISTRAR 11 1968 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Hilda Maud Singer			2a. DATE OF DEATH Apr Month 2 Day 1968 Year			2b. HOUR 11:10 P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/26/23		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL			12b. KIND OF BUSINESS OR INDUSTRY TEACHER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12 N. Farquhar St.		
14. FATHER'S NAME First John Middle S. Last Wetnight			15. MOTHER'S MAIDEN NAME First Maud Middle Lewis Last Lewis								
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, na, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-22-6821		17. INFORMANT Address CLARENCE SINGER UNION BRIDGE MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340x <u>Branchopneumonia, bil.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 345x										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
										8 years	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Dec. 28</u> , 19 <u>67</u> , to <u>Apr. 2</u> , 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>April 2</u> , 19 <u>68</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.											
22b. SIGNATURE Victor L. Ramos, MD DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/3/68			
22d. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.						22e. ADDRESS Western Maryland State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 5-1968		23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW		23d. LOCATION (City or Town) (County) (State) RANDALLSTOWN MD					
24. FUNERAL DIRECTOR DW Hantler - Union Bridge, Md ADDRESS						25a. REC'D BY REGISTRAR DATE APR 5 - 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Briscoe</i>			First Middle Last			2a. DATE OF DEATH Month <i>4</i> Day <i>17</i> Year <i>68</i>			2b. HOUR <i>5:25</i> M		
3. SEX <i>MALE</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>JAN 26 1883</i>			6. AGE (In years lost birthday) <i>85</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>WASHINGTON</i> Md.		
10. CITY OR TOWN OF DEATH <i>Williamsport</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Williamsport Sanitarium</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>merchant</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>West Virginia</i>			13b. COUNTY <i>Jefferson</i>			13c. CITY OR TOWN <i>Harpers Ferry</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>Gen. Moore</i>			14. FATHER'S NAME First Middle Last <i>Samuel Smith</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Betty Ann Hough</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>233-34-3344</i>			17. INFORMANT <i>Mrs. William Reed</i>			Address <i>Harpers Ferry, VA</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Debilities ulcers and probable pneumonia</i> <i>342 X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Parkinsonism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>17</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>350 X</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William O. Rexrode M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>May 1, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>William O. Rexrode M. D.</i>						22e. ADDRESS <i>145 South Prospect Street</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Apr 19, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Harper's Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Harpers Ferry Jeff. W. Va.</i>		
24. FUNERAL DIRECTOR <i>C. H. Shuler Jr. Charles Town, W. Va.</i>						25a. REC'D BY REGISTRAR DATE <i>MAY 6 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

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STATION 12123

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06297				06303							
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
DORY THEODORE STEVENS				APRIL Month 22 Day 1968				10A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		2/21/1887		67 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				WASHINGTON Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give nearest address)				12a. USUAL OCCUPATION (Kind of work done during most of working life)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON CO. HOSPITAL				RETIRED		MFG. CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		WASHINGTON		HAGERSTOWN		NO <input type="checkbox"/>		334 JEFFERSON ST.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
JOSHUA JUNIOR STEVENS				MARY KATHERINE TRUMPOWER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO				218-01-18294		MRS. HVLAND GRIFFITH HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>403X</i> <i>leukemia</i>								2 WKS			
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <i>446X</i>											
(b) <i>Nephrosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>Common duct obstruction, stone. Cholelithiasis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-31</i> , 19 <i>67</i> , to <i>death</i> , that (I) (we) last saw the deceased alive on <i>4-22</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>Robert F. Gackle</i>										<i>4-23-68</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
<i>Robert F. Gackle</i>				<i>Hagerstown Md</i>							
23a. BURIAL, CREMATION, REMAINS (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<i>BURIAL</i>		<i>4/25/68</i>		<i>REST HAVEN CEM.</i>		<i>HAGERSTOWN WASH. MD.</i>					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
<i>W. J. Perment, Hagerstown, Md.</i>				<i>APR 26 1968</i>		<i>Charles J...</i>					

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WASHINGTON
OFFICE OF THE
DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

[Large block of extremely faint, illegible text, likely a memorandum or report body.]

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06298-36304

1. DECEASED-NAME (Type or Print) <u>William LeRoy</u> <u>Wall</u>			20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <u>4</u> Day <u>7</u> Year <u>1968</u> 2b. HOUR <u>2:15</u> PM		
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>1-27-1914</u>	6. AGE (In years last birthday) <u>54</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>
70. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hospital</u>		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Joppa</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <u>Harry W.</u> Middle <u>Wall</u> Last <u>Wall</u>			15. MOTHER'S MAIDEN NAME First <u>Carolyn</u> Middle <u>(Unknown)</u> Last <u>(Unknown)</u>		
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Sarah R. Wall, 550 Old Joppa Rd. 21085</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u> <u>1.5 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>					
190. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> EXAMINER'S NAME (Type) <u>EDWARD W. DITTO, 111 MD.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Apr 7, 1968</u>	
230. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		231. DATE OF BURIAL <u>4-10-1968</u>		232. LOCATION (City or Town) <u>Loudon Park Cemetery</u> (County) <u>Baltimore</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>APR 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2893

EDWARD W. LITTON, JR.
117 WASHINGTON ST. BOSTON, MASS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last KATIE REBECCA WIDDOWS			2a. DATE OF DEATH Month 4 / Day 7 / Year 68		2b. HOUR 9:20 P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH NOVEMBER 15, 1883		6. AGE (In years lost birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 305 NORTH MULBERRY STREET	
14. FATHER'S NAME First Middle Last JOHN RIDENOUR		15. MOTHER'S MAIDEN NAME First Middle Last CECILIA ROWLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. HELEN CHANEY, 305 NORTH MULBERRY STREET, HAGERSTOWN, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion, left coronary artery 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs Unk Unk
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cholelithiasis, unbleeding					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (the hospital) attended the deceased from April 9, 1967, to April 8, 1968, that (I) (we) last saw the deceased alive on April 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. L. Packer		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED APRIL 9, 1968		
22d. PHYSICIAN'S NAME (Type) LAWRENCE L. PACKER, JR. M.D.		22e. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/10/68	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MARYLAND		
24. FUNERAL DIRECTOR Nelson L. Eschelberger		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECORDS OF DEATH

1923

NAME

AGE

SEX

DATE OF DEATH

PLACE

CAUSE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

MARRIAGE

CHILDREN

RELIGION

REMARKS

SEX

AGE

SEX

DATE OF DEATH

PLACE

CAUSE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

MARRIAGE

CHILDREN

RELIGION

REMARKS

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AGE

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DATE OF DEATH

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CAUSE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

MARRIAGE

CHILDREN

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EDUCATION

MARRIAGE

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

MARRIAGE

CHILDREN

RELIGION

REMARKS

SEX

AGE

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month		Day	Year	2b. HOUR
Margaret		Lee	Wiles	April		29	1968	7:15	A.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
female	white		October 27, 1913		54		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Washington Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hosp.		Weaver		Silk Mill					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		213 Summer, St.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
William D. Rice		Fannie Lamp									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
no		219-20-2876		Mr. Charles E. Wiles Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma urinary bladder with metastases</u>										48 hrs 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1810</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
John J. Donoghue M.D.										4-30-68	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS	
John J. Donoghue, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-2-1968		Rose Hill Cemetery		Hagerstown, Md.					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home Hagerstown, Md.				DATE MAY 2 1968		Charles Judge					

MEDICAL CERTIFICATION

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• **Dr.**

• 4854

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First MIDDLE Last BETTIE COYLE WOLFINGER			2a. DATE OF DEATH APRIL Month 30 Day 1968			2b. HOUR 3 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10/21/1921			6. AGE (In years birth day) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give the address) WASHINGTON CO. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of time before death) SECRETARY AIRCRAFT MFG. CORP.			12b. KIND OF BUSINESS OR OCCUPATION CORP.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1742 DUAL HWY.			
14. FATHER'S NAME First MIDDLE Last THURMON CLEVELAND FIREY			15. MOTHER'S MAIDEN NAME First MIDDLE Last SARAH H. KREPS			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) NO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 213-18-9845		17. INFORMANT MR. RICHARD C. WOLFINGER			Address FREDERICK MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 4300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Not known</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 330X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1-23-, 1968, to 4-29, 1968, that (I) (we) lost the deceased on 4-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Arthur Riego</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/30/68		
22d. PHYSICIAN'S NAME (Type) ARTHUR RIEGO		22e. ADDRESS 119 E. Antietam, Hagerstown										
23a. BURIAL CREMATION REMOVED BURIAL		23b. DATE 5/2/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE J. C. Judge						

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PROTEINASE INHIBITORS

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